Rural Welfare Services

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PREFACE

Social Welfare Service of rural communities has been called "the last frontier of social work." What is ordinarily known as social welfare work was organized first in cities, because there special handling of acute social needs under professional leadership became a necessity of organized society. With the recognition of social disorganization, insecurity, and urbanization in rural communities, more rural social services are being called for and organized.

It appears appropriate now to attempt a comprehensive treatment of types of rural social welfare service, to appraise at least a part of what has been done, and to state directions and methods of further planning and development. Possibly this will serve as an orientation for some of the professional social welfare workers and for volunteers already engaged in useful tasks. The book may also be an introductory treatise for those who plan to do professional social work or for anyone wishing to start an exploration of the programs here considered.

Rural social workers are usually generalists, it has been remarked, even when they are working in an agency rendering specific services. Hence no precise definition of rural social welfare work is being attempted. The main emphasis in this book is on those services which, in the author's opinion, are generally regarded as in the scope of social welfare work in rural communities. But there are certain aspects of rural social welfare work that must of necessity go untreated, even unmentioned here. For example, it has not been possible to take up social work in institutions or in many of the agencies, including the field of child welfare, that engage in both urban and rural activities.

Many activities closely related to social welfare work are only briefly referred to, in terms of their meaning for professional welfare workers. Obviously no attempt can be made to consider all civic, agricultural, religious, or educational programs in rural communities. However, the agricultural extension worker, the educator, the clergyman, the officer of the general farm organization

and the cooperative are among those for whom the book is prepared. These persons will determine to a large degree what is done about rural social welfare work. Their agencies are part of the total rural social resources. Their cooperation is essential.

Thus this book is presented as an interpretation of important social welfare services available to persons living in the rural communities of the United States. The activities taken up are those for aid to persons in need, for prevention of unwholesome conditions, and for promotion of social security, health, and stability in rural areas. In order to make the book of as wide use as possible, a list of agencies has been compiled for the volume, and the selected references have been arranged as a guide for those who wish to do further study.

B. Y. L.

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Chapter 1 · RURAL TRENDS AND NEEDS

During the Past Few Decades, evidence has been accumulating of the social needs that social welfare agencies, governmental and voluntary, are organized to meet. It is being recognized that there are large numbers of handicapped, neglected, and dependent persons in rural communities. There has been shifting of population as many people have migrated in search of better opportunities than those prevailing near their homes. In rural communities incomes and standards of living have become relatively low compared with urban areas. A general sense of insecurity is felt. Marked signs of social disorganization have been noted. There has been a degree of urbanization of rural communities. Provisions for rural education, recreation, health, and welfare services have long been regarded as inadequate. In this chapter we open our consideration of social welfare activities with a brief summary or inventory of outstanding rural social trends and needs, as a basis for the later, more detailed discussions of programs under way, of the central problems involved in these services, and of the elements of planning needed in the future.

The Significance of Rural Communities. Robert M. MacIver once wrote that "one of the broadest and most revealing of all social contrasts is that exhibited in the differences of rural and urban life. . . . City and country are . . . the two great generic modes of human habitation." [1] Soil contact, say some of our rural philosophers, is a part of the natural order of things by which human beings should live. To have a truly human system of arrangements, they contend, people must live close to the earth. Thus many rural social scientists point to the small community as the "seed bed" of society. Rural communities are widely recognized as important sources of the populations of cities.

Art, science, business, government are but the fruits of civilization—the roots are certain elemental or basic qualities, such as good will, neighborliness, fair play, courage, tolerance, patience. This is the thesis of one of the ablest advocates of the small community,

Arthur E. Morgan, who maintains that the basic qualities generally are learned best in the intimate and friendly world of the family and the small community, which is better equipped than the large to support the values recognized as highest and best in the human race. Thus a good life for many persists in rural communities. That people in small communities associate with each other on a personal, face-to-face basis is one of the fundamental facts of American life, and this is a social resource of first importance.

The rural community "is the proving ground for all we would undertake in our national life," said Mrs. Raymond Sayre of the Iowa Farm Bureau in her presidential address before the American Country Life Association in 1941. "In the little community, no matter how remote or how humble the setting, there is drama and destiny. . . . The community approach to our problems—far from being the easiest because of its smaller area—is definitely the most difficult and perhaps, therefore, the most neglected. It is on the more personal and intimate level of the community that plans and programs arouse hostility and concern." [2]

The Numerous Rural Communities. The people living in rural areas were 94.9 per cent of all the people in the United States in 1790, and 43.5 per cent of the total number of persons in 1940, the date of the last population census.[3] The definition of "rural" as used by the Bureau of the Census includes people living in the open country and in centers having up to 2,500 population. This is the generally accepted definition of the term in the United States.

The total rural population in 1940 was 57,245,573 persons, divided into two groups: (1) the farm population of 30,216,188 persons, and (2) the rural non-farm population—that is, persons living in hamlets and villages and in country homes not classified as farms—of 27,029,385 people. By 1947, these figures were almost reversed. The Bureau of the Census estimated that the rural non-farm population in that year was about 30,896,000 persons, a gain of 14.3 per cent since 1940; and that the farm population was about 27,305,000 persons, a decline of 9.6 per cent from 1940. For the first time in the history of the nation, the rural non-farm population was reported to be in excess of the farm population. During the same seven-year

period, the Bureau estimated that the urban population increased from 74,424,000 to about 83,860,000, or 12.7 per cent.[4]

The farm population, however, increased for the second successive year in 1946, according to the Bureau of Agricultural Economics, which makes an annual estimate. In January, 1947, the number of persons on farms was reported to be 2,360,000 persons above the figure of 1945. Men returning to farms after being discharged from the armed forces made up the most important source of increase in the farm population during these two years.[5]

There were 13,288 incorporated places [6] with a population of less than 2,500 in 1940. There were also, in 1940, 2,826 towns and cities each having 2,500 to 10,000 population. Roughly 2,000 towns and villages which had less than 2,500 population in 1900 had passed that mark by 1940.[7] These figures themselves illustrate the task faced by those who would administer or organize or extend rural social welfare services. Another factor of first importance is the settlement of farm operators on scattered farmsteads. There are nations in the world in which those who cultivate the land live in villages and go back and forth to their lands in order to work them. In the United States, many of the villages are service stations for farmers. Many of the farmers' agencies and institutions are located in villages, and it is frequently stated that rural life is increasingly town- and village-centered.

There were 3,070 counties in the continental United States with rural population. Of all the counties in the continental United States, more than three-fourths had a population of less than 50,000 in 1940; two-thirds had less than 25,000 people; and one-fourth, less than 10,000 persons. In 1940, while 43.5 per cent of the population lived in rural areas, 52.5 per cent of all children under five years of age lived there. In rural farm areas in 1940, 40.7 per cent of all persons were eighteen years of age and under; in rural non-farm areas, 35.1 per cent; in cities, 28.3 per cent. At the other end of the scale, however, persons over sixty years of age made up roughly 10 per cent of the total population of rural farms and rural non-farm areas and of cities alike.[8] In 1940, men far outnumbered women in farm areas (111.7 men per 100 women), whereas women outnumbered men in urban areas (95.5 men per 100 women).

The foreign-born white population in 1940 numbered 10,341,276 persons, of whom only 20.0 per cent were living in rural communities. In 1940, 13.5 per cent of the rural farm population was Negro, compared with 7.3 per cent of the rural non-farm population and 8.0 per cent of the urban population.[9]

A great westward movement of population took place between 1940 and 1946, according to the Bureau of the Census. This trend resulted in an increase of 3,281,000 persons, or 33.9 per cent, in the Pacific states of California, Oregon, and Washington. The over-all increase in the remainder of the United States was reported to be about 3,712,000 people, or only 3.0 per cent, above the total for 1940.[10]

Rural Families. Farming is an occupation in which a high degree of family cooperation is essential in most instances. The economic processes are such as to encourage family participation. Many farm boys serve a natural and unpaid apprenticeship on the home farm. Sons of farmers are more likely than most urban dwellers to follow the occupation of their fathers. Rural families tend to spend considerable time in their own homes. One sample study has indicated that rural boys spent 5.5 evenings a week in their own homes; urban boys, 3.7 evenings. Rural girls spent 5.3 evenings a week in their homes; urban girls, 3.9 evenings.[11] There is much evidence that rural people generally find a greater security in the family than do urban dwellers.

The average rural family is larger than that of the city, although the size of both has been declining. The average size of urban families declined from 4.5 persons in 1910 to 3.61 persons in 1940; the average size of rural families declined from 4.6 persons in 1910 to 4.01 persons in 1940.[12] The net reproduction rate of the farm population is much higher than that of the urban population, with the rural non-farm population between them, according to data summarized by Louis I. Dublin.[13]

It was reported in 1940 that 20.4 per cent of the farm population had completed less than five years of schooling, compared with 13.6 per cent of the rural non-farm population and 11.3 per cent of

the urban population. As for completing college, only 1.5 per cent of the farm population had had this amount of formal education, compared with 4.7 per cent of the rural non-farm population and 7.0 per cent of the urban population.[14]

When it comes to physical facilities, there are marked disadvantages for rural families. In 1940, the Census Bureau reported that 60.2 per cent of farm families had radios, compared with 79.0 per cent of the rural non-farm families and 91.9 per cent of the urban families. Percentages of other mechanical facilities in houses, as reported by the Bureau of the Census, are shown in Table 1.

TABLE 1

HOUSING FACILITIES

	PERCENTAGE IN HOMES		
Facility	*Rural Farm*	*Rural Non-Farm*	*Urban*
Running water in dwelling	17.8	55.9	93.5
Flush toilet	11.4	45.0	90.8
Bathtub (exclusive use)	11.8	40.8	77.5
Central heating equipment	10.1	27.0	58.2
Electric lighting	31.3	77.8	95.8
Mechanical refrigeration	14.9	38.7	56.0

Source: Bureau of the Census, 16th Census of the U.S., Housing, 1943

In the ten-year period from 1936 to 1946, the percentage of electrified farms increased from about 11 per cent to about 53 per cent, the Rural Electrification Administration reported. Electrification has contributed power for farm production and for home work. It has been called the "kingpin" of satisfactory home and farm life. It has helped to make farm life more attractive to young people. It has been an important factor in lightening the burden of work of the farm homemaker. Large programs of further expansion are in process, which may soon make it possible for a high proportion of farms to have electricity.[15]

Economic Trends and Conditions. Income per person of those living on farms has been consistently lower than that of persons not on farms. Table 11 is constructed from recent data of the Bureau of Agricultural Economics.[16]

TABLE II

PER CAPITA ANNUAL INCOME

Years	*Persons on Farms*	*Persons Not on Farms*
1935–39 average	$243	$ 603
1944	688	1290
1946	779	1288
1947 (preliminary)	853	1365

It is not possible to make precise comparisons of income of farm people with that of town and city people because of the difficulty of estimating the value of the "things furnished" or the "income in kind" that comes from the ordinary processes of farm life. No matter how these are estimated in cash terms, however, there is agreement among authorities that income of farm people is substantially lower than that of urban people. One must also note that food, clothing, and fuel on a farm are not secured without labor or even costs in terms of cash. In actual practice, farm people furnish themselves with food, clothing, and cash by means of unpaid family labor.

This practice is strikingly revealed in the extensive sample studies published by the United States Department of Labor in its reports on family spending in wartime, which included urban, rural non-farm, and rural farm families. Particular attention was paid to the process of securing an adequate sample. The figures for the full year 1941 indicated an average income from money and non-money sources of $1,655 for farm families, $1,539 for rural non-farm families, and $2,578 for urban families. Yet of non-money income in kind, farm families had on an average of $521; rural non-farm families, $228; and urban families, $169. Non-money income was largely in the form of food, housing, and fuel.

A similar disparity is noted in gifts and contributions and in certain other expenditures, as given in Table III, from the same source.

Rural Poverty. Rural poverty has been widespread and of long standing, and rural slums are numerous. In 1930, for example, 50 per cent of the nation's farms marketed a total of only 10 per cent of the products that went to market. In 1940, according to the Census of Agriculture, nearly three million farms, about half of

the total number, marketed or used products valued at less than $600 per farm annually. Who are these people with low incomes and standards of living? They are largely tenants, sharecroppers, and migrant laborers, white as well as Negro. They are the people most often overlooked by social legislation. The low-income farm producers have been one of the largest pools of inadequately used manpower in the nation. During the war large farms often could not make notable increases in production because they were hampered by lack of machinery and manpower. The small, poor farmer was able to respond because he and his family had an opportunity fully to use their time and animals and equipment. On the whole, farmers in spite of inadequate equipment made remarkable increases in production.

TABLE III

AVERAGE ANNUAL EXPENDITURES IN GIFTS AND CONTRIBUTIONS, ALL FAMILIES AND SINGLE CONSUMERS (1941)

	Urban	*Rural Non-Farm*	*Rural Farm*
Gifts	$42.01	$20.26	$16.52
Support of relatives	26.61	11.76	5.81
Donations to others	2.55	1.40	.91
Community Chests, etc.	5.79	1.10	.49
Religious organizations	28.42	18.59	15.56
Red Cross, U.S.O.	3.72	1.43	1.16
Other, including foreign relief	3.39	.56	.82

Source: U. S. Department of Labor. *Family Spending and Saving in Wartime*. Bulletin No. 822. 1945.

A study of the sore spots in American rural life was made by Carl C. Taylor, Helen W. Wheeler, and E. L. Kirkpatrick for the purpose of revealing in broad outline "the major factors that tend to reduce approximately one-third of the farm population of the nation to submarginal standards of living." Even in the year of 1929, 1,700,000 farm families with 7,700,000 persons used, traded, or sold products valued at less than $600 per farm, and thus had inadequate purchasing power. More than a half million farms in the United States had land so poor that it was incapable of yielding a satisfactory living. During the depression at least 3,500,000 families,

or more than one out of every four rural families, received public assistance at some time. One-third of the farm families lived in homes that would in urban communities be called slums.[17]

Rural-Urban Relationships. In 1946, Carl C. Taylor of the United States Department of Agriculture gave the National Convocation on the Church in Town and Country the following summary of trends in American rural life:

> The four long-time consistent trends in American rural life which are most obvious to the student are:
>
> 1. That a steadily diminishing percentage of American people live on farms.
>
> 2. That there is a steady long-time trend of increasing intermingling of agriculture and other occupations.
>
> 3. That there is a decline in the operation of the agricultural ladder as a method of gaining farm ownership and as a means of insuring economic and social security and
>
> 4. That there is a constant shift from dependence on local, simple face-to-face (neighborhood) types of association, to non-local, complex, relatively impersonal types of organizations and contacts.[18]

In the past few decades there has been a marked development of part-time farming. This has been described as "a way of life in which the family lives on a small farm, but draws its income from two or more sources, one of which is the farm." The other source is usually a job in trade or industry or a profession or a job on other farms of a community. A good many people work full time in a town or city and live in the open country, having a garden and keeping poultry. Such persons are perhaps more accurately described as rural residents with city jobs, but there has never been any sharp distinction between these residents and the part-time farmers. In 1939, according to the 1940 Census of Agriculture, over 900,000 farmers worked "off the farm" more than 100 days. Many uncounted thousands of other farmers worked fewer than 100 days.[19]

Farmers are more dependent on city buying power than is city industry on farm buying, it was stated in a memorandum of the United States Department of Agriculture entitled *Post-War Plans No. 3.* Farm and rural people have furnished in recent years less than one-fifth of the national market for goods and services, whereas more than three-fourths of all farm products consumed in this

country are bought by non-farm consumers. A fundamental relationship exists between the income of city dwellers and the income of farmers. Demand for farm products is greatest when city people are fully employed.[20]

"Rural" and "urban" are becoming "terms of degree, measurable by gradations out from any city center," Edmund de S. Brunner and J. H. Kolb concluded in their study of rural and urban relationships for the President's Research Committee on Social Trends. Direct contacts between rural and urban people have greatly increased. Indirect contacts, cultural and social, perhaps just as meaningful, have also multiplied. Thus "certain differences in the characteristics of the urban and rural population have grown markedly less." Adjustments have followed. "City, village and country have been brought closer together. . . . Society cannot be adequately described or analyzed in terms of the old arbitrary bifocal divisions." These are trends of significance to those who make programs and determine policies.

Brunner and Kolb studied 347 counties surrounding 18 urban centers, about 19 counties per center. These areas comprised 10.2 per cent of the population of the nation in 1930. In general, birth rates of counties were lowest nearest the city and increased as distance between county and city became greater. The study concludes that "the farm population makes a disproportionately large contribution to the youth of the nation and the city profits by this differential contribution." The nearer the city, the smaller the average size of farm per county. The counties nearest the cities also had the lowest proportion of mortgaged farms. Farming near the cities tended to become more specialized than in the more distant counties.[21]

Rural Education. During recent years, teachers' salaries in rural schools have averaged only one-half of those of urban teachers; expenditure per pupil in rural schools has been about 70 per cent of the urban level; and taxable property value per pupil in the country has been equal to only about one-half of that in the city. There is undoubtedly a tendency for rural teachers' salaries to have some relationship to other rural professional salaries and to rural family incomes generally. John K. Norton and Eugene S. Lawler generalized

about the school situation, urban and rural: "The poorest schools are generally found in poverty communities where the home environment is not of the best. In other words, the children who most need good schools usually get the poorest schools." [22] It was estimated in late 1946 by the National Education Association that as many as 350,000 school teachers, urban and rural, had quit the classrooms of the nation since 1941, and there were not enough teachers entering or re-entering the profession to replace them. Ten states reported that a total of 61,700 children were being deprived of all schooling because no teachers were available. Since the rural school situation generally has been less favorable than that of cities, presumably rural schools were more adversely affected than urban schools by the shortage of teachers.

Of the rural schools specifically, compared with urban schools, Norton and Lawler state: "Schools which annually spend $800 or less per classroom unit are for the most part in rural areas and a larger percentage of their budget is for teachers' salaries. In order to make their limited resources suffice, they sometimes place a large number of children in a classroom, thus increasing the amount available to finance the classroom but decreasing the opportunity of the teacher to give the children individual attention." The farm population, with only about one-tenth the national income, has had to finance the education of one-third of the nation's children. The Southern farm population, with only 2 per cent of the national income, has been educating 14 per cent of the children. These educators, and many others, recommend federal aid for education.

As for the quality of rural education, much more difficult to consider in precise terms than its finance, Norton and Lawler point out that "a teacher of insight and sympathy may do wonders, even though receiving a poverty wage. . . . Most teachers of insight and sympathy, however, are drawn to schools that pay well." The same authors also recognize that "some children in low-expenditure schools may live in communities where the pattern of living tends to provide a natural and healthful participation in the affairs of real life."

Rural Churches. Churches in rural communities, according to the federal Census of Religious Bodies, are far more numerous than city

churches, but the rural institutions are much smaller than those of urban places. Rural churches in 1936 reported an average of 133 members, whereas city churches reported an average membership of 541 persons. Rural churches send many of their members into city churches as people migrate from farm to town and city. Recently it was found in Terre Haute, Indiana, that half of the members of Protestant churches there were not born in that city but had come to Terre Haute from smaller places. Among these migrants to cities are many of the ministers and members of churches.

It is generally acknowledged by students of the rural church situation that numerous institutions are too small to become efficient units for administration of programs; that there is an uneven distribution of local churches; that there is inadequate physical equipment; that the professional leadership has not had training in terms of the tasks to be performed; that the typical program is a meager one. In this situation, the rural churches generally have not given leadership in the development of rural social welfare services.

Rural Opinion Regarding Social Welfare Services. The public generally looks on social workers with a feeling that "ranges all the way from amused intolerance to real antagonism." Thus Martha C. Barnes wrote of the general situation in 1946.[23] If her observation is valid for all communities, it probably is even more accurate for the rural than for the urban public. The rural public is slowly coming to recognize the numbers of handicapped, dependent, delinquent, and neglected persons in its midst. Yet it often regards social welfare as something connected with a salvaging operation in a city slum.

The rural public has always looked with great sympathy upon those who have come to want because of the death or illness of the breadwinner, but it has looked with much less concern on whole families in distress because of a national calamity. There are many areas in which rural leaders do not wish their young people "to be too joyous," and many in which the residents "work hard, take things hard and talk about it hard," with as yet little realization of the techniques and organization needed for achieving a decent, free life for the unfortunate or disadvantaged people in their midst.

Much rural opinion can be explained only in terms of paradox.

Farm people do not like government interference and control, it is said, yet farm people have asked for special government farm programs. Farm people do not like coordinated social planning, yet farm people engage in considerable planning. Farm people do not want the bureaucrats to tell them what to do, yet farm people are engaging in a gigantic enterprise of soil conservation, planned by a government bureau. Rural people want to emphasize self-help, it is said, yet an editorial in *Country Gentleman* on the projected program of federal-state financing of new hospital construction states, "Farm areas generally are in greatest need of hospitals and health clinics and should benefit most from this program." [24] Rural people emphasize getting to work on one's own problems, yet rural people have often sold their products to distant lands whose fluctuating currencies influenced the market. Rural people are accustomed to old-fashioned individualism, it is said, yet rural people engage in more than 90 per cent of the business of cooperatives engaged in purchasing and marketing.

There is still another paradox. Sometimes urban social workers engaged in fund-raising remark that rural communities are reluctant to join in. But rural people feel that they are contributing to the social welfare in various indirect ways. They do not like to be told that they are unwilling to contribute to social welfare campaigns, because they feel that they are bearing an undue burden in educating many children who run off to cities. Rural people also feel that wealth has been concentrated in cities and that, while their own rewards are generally moderate, others have made fortunes by handling products that have left the farm.

Rural people recall that in times past, such as the years 1929–33, the farms literally have been, in part, the cities' relief agencies, because many urbanites fled for a refuge to the farm when a depression hit the cities. When rural estates are settled, the city children as well as the rural children inherit, and since there is more migration from country to city than in the opposite direction, many city children benefit in this process. Thus rural people point to evidence that in many ways wealth goes out from rural communities to city dwellers, and they believe that through these processes they already contribute to the general social welfare.

Chapter 2 · EVOLUTION OF RURAL SOCIAL WELFARE SERVICES

MORE THAN SEVENTY-FIVE YEARS AGO Louisa Schuyler, a member of an old New York family, visited an almshouse, and a report she made reads as follows:

The summer of 1871 had come. I had never been in a poorhouse, and, before asking others to go, wished to visit one myself, and alone. I wished to know from personal experience whether what I had read of such places was substantially true, and, if so, whether the plan I had in mind seemed sound and practical.

The poorhouse selected was that of Westchester County, situated on the road between Tarrytown and White Plains, and five or six miles from our country home. It was the fourth largest poorhouse in the State, with a population of about 370 pauper inmates. It was an attractive-looking building of gray stone, well proportioned, set back from the road, fine trees about it, the grounds sloping down to a clear running brook.

Our first visit was made in June. The surprised keeper and his wife greeted my sister and myself cordially, rather doubtfully, too, for we were so much interested in seeing everything; we took a few comforts for the sick; were taken through the building, but made no comment on what we saw. And what did we see? We saw sixty children, young and old, in the care of an old pauper Irishwoman. Her illegitimate daughter assisted her; and that daughter's illegitimate child was one of the children. (This we ascertained later.) To remove those children from the poorhouse, to get them away from those influences, would seem the first thing to be done.

We found sick people, very sick people, without a nurse to take care of them. The keeper's wife was kind and did what she could; but the nurse in charge, old Hannah, was herself a pauper, too stiff from rheumatism to easily rise from her chair, with a paralyzed arm and twisted wrist —and this with desperately ill and dying people and no resident physician.

We found the insane in cells, suffering from cold and hunger, their attendants being paupers; one violent case in a sort of dungeon with a

ceiling too low for him to stand up; vagrants, abandoned women—no separation of the sexes.[1]

This event was one of the milestones in the development of rural social welfare services because it was part of the process that led to the founding, by Miss Schuyler, of the State Charities Aid Association in New York, one of the pioneering organizations in the development of county agencies and institutions serving rural communities. The Association, considered below in Chapter 15, is an organization of citizens which has promoted state and local programs in public welfare, public health, and mental hygiene. Its members continue to visit public charitable institutions.

Historical Antecedents. The origins of what is today a many-sided development in social welfare services for rural communities are found in many streams of interests and efforts.[2] Much of what we now have may be traced to English law because that was what the settlers of many of our states knew. In the early days, rural social service was largely unorganized. There was, for example, the informal charitable work of parishes, fraternal orders, and individuals; seldom is there a rural community, in which there is not at least one person sufficiently concerned to do something on behalf of the sick, the bereaved, the poor, and the handicapped.

The United States followed England in establishing almshouses. In England they were generally called workhouses, and in the United States, poorhouses. The rural institution was named the county home or county farm, but to the public it was the poorfarm or the poorhouse, and there was a stigma attached to residence in a place housing paupers. This vague emotional attitude toward the unfortunate may also have come from English social heritage. There, with the breakup of the feudal system, under which the landed classes generally cared for dependents in some way and the church provided some organized charity, the modern problems of poverty were faced at first in an irresponsible fashion. Begging and destitution were regarded as criminal. There was a time in sixteenth-century England when the beggar was whipped, and for further offences could be put to death. The effect of such harsh measures was to encourage the pursuit of robbery. In the early days of the industrial

revolution, destitution came to be thought of as a necessary evil, lesser than that of overpopulation. But widespread starvation could not be permitted, and consequently the poor were concentrated in workhouses, where their lot was made unattractive.

The Rural Almshouses. No attempt was made in the United States or in England to study the causes of destitution. Old and young were herded together, as well as the tubercular and the insane. Poverty was usually regarded as a disgrace, and those who had means were thought to have them as a result of their frugality and industry. Not until the second half of the nineteenth century did scholars gain better knowledge, philanthropists become interested, and public opinion develop in behalf of more systematic and humane treatment. In rural America we still have many county homes, largely for older people; to some extent such places still house the mentally ill; and it is still a disgrace to live there. The number of such institutions now operating is not known. During the past twelve years, with social security measures, there has been much public pressure to eliminate the county almshouse which gives only custodial care. In the states of Illinois and Indiana, where the institution was retained, the able-bodied persons were encouraged to take old-age assistance and live elsewhere, and the institutions are becoming public nursing homes.

Outdoor Relief. Another early movement, directed in part against the shocking conditions of the almshouses, was that for the organization of outdoor relief under local governments. Dependent people were given orders for food and other supplies on merchants, or cash grants, or, in some instances, baskets of supplies were given out by public officials at intervals from the basement of the county courthouse. Poor relief has been a continuing function of the New England towns and of the counties of the nation. Prior to the year 1933, in the rural areas of the nation, most of the poor relief distributed was that which came from village, township, or county funds. Private charity has only occasionally been organized in rural America, and the rural areas did not participate in the private charity organizations of the cities, which were begun to provide something more thorough than public outdoor relief.

The supervision of local poor relief is frequently the duty of an unpaid official or one of many other duties of a paid town or county official. Rural people have generally believed that it is a very simple matter to help the poor and to discourage those in want from asking too often or too much. Rural people want their local property taxes to be as low as possible. Therefore they want their county and township poor relief grants to be as low as possible. The overseer of the poor in many places still works without reference to a family budget. He hands out a grocery order for a small amount, and if the family comes back for another too soon, he may threaten to have their children committed to a public institution. But during these latter years there has been a widespread growth of county public welfare departments, which administer what is now widely called "general public assistance."

Widows' Pensions. There has been a constant struggle to take certain dependent persons from the jurisdiction of the general poor laws under local administration. One of these movements was early known as that for "mothers' pensions." [3] In 1911, Illinois amended its juvenile court laws so as to provide for widows' or mothers' pensions. Many other states followed until, by 1931, 2,723 counties of the nation were authorized to provide public aid of this type, but only 1,490 counties were actually making the provisions. Where available in rural counties, widows' pensions were administered by the courts. Most state laws were not mandatory. In most instances, the county or other local unit was called upon to provide the money, and about half the counties never put up any money for the purpose. Grants per family were usually very small. The Social Security Board reported, in 1937, the results of a study which showed that in 1934 only 109,000 families throughout the country were receiving widows' pensions, and more than 51 per cent of these persons were living in cities having 50,000 people and over. Now the federal-state program of aid for dependent children, begun under the Social Security Act of 1935, provides one of the national forms of "categorical public assistance."

General Public Health Work. As more and more rural people moved to villages and towns, and the problems of organized life together

were faced, the necessity of services to protect and advance the public health came to be recognized. "Germs know no boundary lines" was a slogan that could easily be understood as interdependence took the place of the earlier, more isolated life. Early experiments took place in Yakima County, Washington; Guilford County, North Carolina; and Jefferson County, Kentucky—counties which co-operated with cities in providing services. Dr. Haven Emerson writes that the first county to establish general local rural health service under full-time professional leadership was probably Robeson County, South Carolina, in 1912. There, in an area wholly rural, with no town of more than 2,500 population, a full-time trained physician began to function in that year as a rural health officer administering a program soon to be in operation elsewhere.[4]

The experience of health departments in 811 counties between 1908 and 1934 was summed up by Joseph W. Mountin, Elliott H. Pennell, and E. Evelyn Flook for the United States Public Health Service in 1936.[5] According to their report, the organization of public health service on a county basis with full-time professional direction assumed "significant proportions" in 1917–18. Prior to 1916, this type of service was maintained entirely by local funds. The states were the principal source of extra-county funds, but occasionally the Rockefeller Foundation and the federal government made grants available. In the year 1920, the Rockefeller Foundation contributed 7.7 per cent of the total of $1,215,141 expended from all sources; in 1931, the Foundation contributed 1.6 per cent of the total of $9,208,402 available for these services. In 1931, the United States Public Health Service was contributing about 10.7 per cent of the total budgets.

The number of counties administering the service grew steadily until 1932, when for the first time the number of counties providing services decreased because of the great depression. Between 1908 and 1934, 811 counties maintained service all or part of the time. Of this number, 541 counties continued the operations through 1934. The counties that maintained the plans were those with the larger populations and those which also had the larger concentrations of urban centers, compared with those that discontinued the service.

A higher percentage of survival was experienced by the larger organizations which were established early. . . . Generally speaking . . . it is the poorer counties that derive a significant percentage of the health department budget from outside sources. . . . In about 40 per cent of the counties the total funds available to the health department were below $10,000 on the year of maximum budget. On the last year of operation considered [1934], the percentages of counties with budgets below this amount increased to nearly 70. . . . During the year of maximum budget, the number of full-time employes in 69 per cent of the counties was less than 5.[6]

In 1935, the Social Security Act provided federal funds that have since enabled general public health services to be provided in about 60 per cent of the counties of the nation.

Public Health Nursing. Public health nursing moved out of the city into the country in the early years of the twentieth century, largely under the stimulus of the National Tuberculosis Association and the various state associations, and of the American National Red Cross. About 1914 the state legislatures began passing laws permitting or requiring counties to use tax funds for employment of public health nurses. By 1920, eighteen states had enacted enabling legislation, and in fifteen states there were state departments of health employing directors or supervisors of public health nursing, whose functions included the responsibility of persuading county officials to support public health nursing.[7] In 1943, in the midst of the war, it could be reported that public health nursing had increased continuously in scope of service and number of nurses. But the number remained static during the later years of the war. Many public health nurses were among the 50,000 nurses who entered military services. In 1943, however, there were still 826 counties and 28 cities that had no public health nurse.

Rural Leaders Consider Public Welfare. When the National (later the American) Country Life Association was organized in 1919, there was a report from a committee on "Charities and Corrections," of which H. Ida Curry of the State Charities Aid Association of New York was chairman.[8] Through the Association and its conferences and publications, rural leaders subsequently considered the

organization of rural social services. The Committee said that it was superfluous to demonstrate the need of social service in rural communities. The recognized situation that had resulted in demands for organized social services in cities also "exists in rural communities as well as in cities, although in slightly modified degree, and sometimes in slightly modified form. . . . Certain lines of social activity are applicable to both."

Valuable experiments were being carried on in various parts of the country, but the Committee knew of no one locality that had attempted to put into operation a program that approached complete services. Any adequate program must be built with knowledge of the "natural and inevitable variety of local conditions. . . . Organized social service to succeed must function along lines natural to the community, and it must use the forces existing in the community, but, at the same time, it is desirable that it should be in touch with some outside agency, equipped to stimulate development and to standardize methods." Organization of public health nursing was recommended. It was further recommended that probation services be organized to assist the courts and that public relief officials employ workers to study the needs of those applying. The antisocial elements of the community should be studied as expertly and treated as adequately as possible. "For the present, perhaps, the county is the best unit for the administration of social programs in most of the states."

By 1925, the Committee on Rural Social Work of the American Country Life Association had suggested the following list of social problems and conditions as roughly defining the field of activity of a county social work agency: "Broken or incapable families requiring aid; abused, neglected, dependent, delinquent and otherwise handicapped children, requiring care or protection by others than their parents; care of the aged dependents; care of feeble-minded and mentally diseased persons; prevention of juvenile delinquency and crime; school attendance and child labor; housing conditions; community organizations for any social welfare movement." [9]

Varieties of Voluntary Agencies. In 1928, Leroy A. Ramsdell reported on a study of voluntary social organizations, indicating that

the total number of county secretaries could then be estimated at 1,500. Since many counties had more than one of these secretaries, probably not more than 1,000 counties were being served, he said. The American National Red Cross then had about 400 paid workers in chapters of predominantly rural counties. Many other counties had chapters with volunteer leadership—in fact, the majority of its 3,500 chapters were in rural territory, and particularly was this true of the work of those departments engaged in disaster relief, public health nursing, home service, and volunteer service. A Red Cross study showed that 1,798 of its chapters had jurisdiction in counties containing no town of 8,000 or more population.

There were in 1928, Mr. Ramsdell found, 124 full-time county secretaries of Young Men's Christian Associations, working in rural counties; 39 county or district secretaries of Young Women's Christian Associations; and 90 secretaries employed by county committees of various state tuberculosis associations. The Boy Scouts of America then had 225 county or district executives responsible for rural organization.

There had been "considerable progress" in thirty years, Mr. Ramsdell noted. But even where a county was reported to be served, frequently not enough of the rural population was participating. Services tended to center in towns and villages, with open-country people relatively "unreached." Many county workers had had no special training for their work. Some of the success in organizing activities in rural counties was traceable to a fairly simple and definite presentation of a program. As a consequence, ability to administer a specialized program was an indispensable qualification of a voluntary rural worker, rather than skill in dealing with the social problems of the rural community.

State conferences of social work were providing forums where social workers could consider rural social welfare work. There were, among others, two stubbornly rooted attitudes, Mr. Ramsdell reported. Rural people were not aware that there were critical rural social problems. "On the other hand, social workers often hold rural institutions and rural ways in contempt. . . . The problem of support is in no small degree a problem of reconciling these two points of view." [10]

Relief in the Great Depression. In the early years of the great depression the number of rural families requiring relief increased rapidly, and it soon became evident that local and even state funds were inadequate to meet the need. In 1932, the Reconstruction Finance Corporation was authorized to loan $300,000,000 to the states for unemployment relief. These loans were to be charged against future grants which the federal government was committed to make to the states for road construction. By 1933, these funds were all loaned, but state and local funds were at the breaking point. In May, 1933, the Congress appropriated $500,000,000 for relief, to be disbursed by the newly created Federal Emergency Relief Administration. In some states the federal government soon was carrying the full load of general relief. For two years the federal government accepted a large share of the expense of the relief of destitute people. By 1935, about 16 per cent of the rural families in the nation were the recipients of relief. There was a rapid turnover of relief cases. In many counties, offices were quickly established. Many of these counties had no conception of the type of person or the type of training needed. In many instances, an inexperienced person was employed to meet the needs with the available funds.

In the seven lean years, 1931–37 inclusive, the cost to the federal government for the relief of destitute rural families was more than $3,500,000,000, not including special loans or agricultural benefits, T. J. Woofter and Ellen Winston reported.[11] In rural communities the cost was less per capita than in urban areas because the grants per case were lower. But to assess the full cost of destitution, one must think in terms of aspects that cannot be measured—human waste, disappointment, discouragement, breaking of family ties, defeated young men and women, disabling illness, undernourished children, and cold and hunger. For literally millions of rural people, there was no way out through their own unaided efforts. And the expenditures by the federal government provided only the bare necessities of life on relief budgets that varied greatly.

In 1935, the federal policy changed. Responsibility for general or home relief was given up, and the federal government assumed responsibility only for work relief, under the Work Projects Administration. In the same year the federal government, under the

Social Security Act, began making grants to the states for three groups in the population: old-age assistance, aid to dependent children, and aid to the needy blind; and for three types of social and health services: child welfare, maternal and child care, and aid to crippled children. The Farm Security Administration was established in 1935 with authority to make cash subsistence grants and loans for rehabilitation and for purchase of farms—all to the low-income farmers of the nation. W.P.A. at one time aided in the support of 25,000,000 persons. It employed an average of 2,130,000 persons, rural and urban, in the six-year period ending June 30, 1941. Certain of its activities particularly reached rural communities. W.P.A., before its termination in 1943, erected or improved an average of ten buildings per county in the United States. It built or improved 600,000 miles of roads, an average of 200 miles per county.

Public Assistance. After the federal government withdrew from general relief in 1935, the result was often comparatively low-grade service through local offices. Many states did not make appropriations for general assistance, and even in 1945, fifteen states were making no funds available for this purpose. It soon became evident that the categorical assistance program left gaps. Not everybody could be classified. Some older people became dependent before the age of 65, when they could have qualified for old-age assistance—some at 55 were as deserving of public assistance as those past 65. By 1940, it could be reported that there was a large unmet relief problem in rural areas, particularly in the South. It was generally believed that relief standards were almost always low where the need was greatest.[12]

In the year 1944–45, the local governments still bore the entire financial burden of general assistance in fifteen states and part of the burden in all states but two, Arthur J. Altmeyer of the Social Security Administration told the House Ways and Means Committee in 1946. In that year, expenditures for general assistance were $1.68 per inhabitant in one state and two cents per inhabitant in another. In 1946, Mr. Altmeyer said, the average payment per case for general assistance was $33.95 per month for essential goods and services. The state average was $49.40 in Washington, the state with the

highest average, and $9.40 in Mississippi, the lowest state. The Washington payment was five times that of Mississippi. In the main, expenditures were highest where average income was high. General assistance is most adequate in cities, Mr. Altmeyer stated, and "is little developed in many rural areas that have been hit hard by problems of transition to peace." He added, "The inadequacy of general assistance in the rural areas is all the more serious because relatively small proportions of their working population have the protection of unemployment insurance."

The categorical public assistance programs had resulted in local services in practically all counties of the nation. They had brought in new helpful supervision, improved standards, and made available new federal funds. They had made possible the employment of many professional welfare workers. In 1946, these public assistance programs were the most extensive public welfare services, for rural communities, to be found in the nation. They were especially significant because farm workers were not covered by unemployment compensation or by Old-Age and Survivors Insurance.

The Rise of the Concept of Public Welfare. Benjamin Youngdahl reports that "all human ills tend to gravitate toward the county welfare office." [13] All states now have a state public welfare department or a comparable agency. The rise of the concept of public welfare is seen in rural as well as urban communities. Not without growing pains have local public welfare offices been developed. Rural public welfare is in its early stages, yet one county department lists seventeen different programs under a staff of three. Specialists in child welfare services operating in about five hundred counties are usually attached to county welfare offices. In one state, Washington, the law provides that there shall be an advisory committee of citizens, who shall find out for themselves the basic conditions that make the program necessary and who shall encourage a preventive program. In other states, advisory groups also function. In Washington, such county committees receive no compensation for their services, but they are permitted, if the county commissioners concur, to have paid secretaries, with expenses furnished jointly by state and county. This legal provision for citizen participation

in Washington was the result of the "advance planning" by public officials with convictions on the subject. They wrote an "educational procedure" into the whole program by statute.

Thus, "the nearest thing to a laboratory in the field of social welfare is the county welfare office," as Edith Foster has put it.[14] Youngdahl further sums up rural experience with social welfare. Many rural counties are large in area, small in staff, and multiple in program. The rural social worker may be a case worker, an administrator, or a public relations worker. Rural social work involves all the known methods of social work. There is no typical rural county and no typical rural social welfare program. There is a wide interest in rural public social work, as "social work is becoming acquainted with the good earth."

Chapter 3 · FEDERAL-STATE PROGRAMS OF PUBLIC ASSISTANCE

THE DESCRIPTION of programs in process will be begun with a consideration of categorical public assistance, the most widespread of all activities.

OLD-AGE ASSISTANCE

In a town in Michigan a former farm owner was applying for old-age assistance.[1] He had sold his farm eight years previously for the purpose of securing cash to pay for treatments for his eyes. But his eyesight continued to fail, and he had spent all the proceeds from his farm in vain. He lived in a tar-papered building. He had never received any form of relief, although he had twice unsuccessfully applied for old-age assistance. He made many statements in his application, among them those about his age, his birthday, his birthplace, the period of his residence in the state. He went on to say that he was unable to earn a regular income of at least $1.00 a day and that he did not have a net income to exceed $1.00 per day. During the past ten years he had not, for six months or more, deserted his wife or failed to support his children under sixteen years of age "without just cause." His record showed nothing that would disqualify him from receiving assistance. He had not divested himself of property for the purpose of qualifying for old-age assistance, and he had not conveyed any property to any person in return for his support or maintenance. He had not been convicted of a felony within the past five years. He was not in need of institutional care, he alleged, and he would not reside in a public institution.

Four days later, the visitor who investigated his statements signed a statement having ten points. The visitor verified his age from the poll records of the township. The township supervisor was consulted about length of residence. The county records revealed no record of a felony. The visitor recommended that the applicant "should have institutional care." Eventually he was granted a cash payment of $19.00 a month, of which he paid $18.00 to the pro-

prietor of a boarding home and had $1.00 for "incidental needs." When he went to his boarding home, he insisted that he would be able to earn a living if his eyesight improved, but there was no provision for medical care, because the administrators of old-age assistance are prohibited from making an allowance for this purpose. If it ever became necessary for him to have medical attention, he would have to apply to the county or to an individual who might be interested in helping. He was one of some two million persons in the United States who received a cash grant of this type.

The General Pattern. Federal-state programs of public assistance were authorized under the Social Security Act of 1935, the same year in which the federal government withdrew from general relief and assumed responsibility for work relief, which was carried on until 1943. This federal-state program is for specific groups—older people in need, dependent children, and the needy blind. The states that wish to participate are required to present to the Social Security Administration their administrative plans for procedure and practices, and the Board requires that minimum standards be met. By amendments in 1939 to the Social Security Act, the federal government requires that all state employees who supervise the activities must be under some type of merit system, and political activities by such employees are forbidden. These provisions create certain safeguards for those benefiting from the law. Field staffs of the Social Security Administration inspect operations for the purpose of maintaining the minimum standards. It is also provided that payments to recipients shall be made in cash and that the recipients of the funds shall be free of dictation in the spending of their funds for the purposes for which they are given. There are also provisions for fair hearings by the state agencies and for the safeguarding of confidential records. These were "new principles" when adopted by Congress.

State and Local Functions. More than three-fourths of the states have provided that the county shall be the local unit of administration for these categorical public assistance programs. The Social Security Administration says that application for old-age assistance must be made through the local welfare office. It is the state law that

decides who shall get aid and how much shall be paid to each person. In general, the requirements of the states with respect to qualifications are as follows: The mimimum age in all states is 65. In many states, a person must be an American citizen in order to receive aid. But no person who is a citizen may be refused aid for any reason connected with his citizenship; he may not, for instance, be refused aid because he has not been a citizen for a certain period. Most states have a residence requirement. Usually a recipient must have lived in a state five years out of the previous nine; a state may not require longer residence than this, nor may a person be refused aid because he has not lived for a specified time in a particular town or county. A person found eligible receives his payments from the state or local agency. The amount received depends upon need and "the amount of money available for old-age assistance purposes." A recipient may not live in a public institution, and he may not receive funds for medical care.

Size of Operations. Twenty-one states were reported in 1945 to have no statutory maximum payment for old-age assistance. In that year, approximately two million older persons received an average amount of $28 a month. In 1946, by a series of amendments to the Social Security Act, the federal government was authorized to make larger contributions than previously to the program, as follows:

The federal government may now share in a maximum individual payment of $45 a month instead of $40. It may pay two-thirds of the first $15 of the average monthly payment, and one-half of the balance of the payments that do not exceed the maximum. Previously, the federal government paid half of the payments up to a maximum of $40. The states, on their part, may contribute any amount above present maximum as they wish.[2]

The federal government shall pay one-half of the sums expended for the proper and efficient administration of the state plans, instead of contributing for administration 5 per cent of the total grants for old-age assistance, the previous provision.

On the basis of state operations in 1945, it is estimated that the increased cost to the federal government for old-age assistance, as a result of these amendments, may be about $123,000,000, over the federal grants of $470,248,000 in that year. (The 1948 amendment

provides for still further increases.) The annual cost of the program to the federal government had increased to that sum from approximately $100,000,000 in 1936 and $170,000,000 in 1937. Payments to individuals are largely determined by the per capita income of the states, and that varies widely. Since the states themselves desire the means tests, it cannot be said that decent provision is made for needy aged in accordance with any reasonable standard.

The "More Rural" Counties. The Social Security Act made no distinction between persons living in rural and urban territory so far as public assistance was concerned. The Social Security Administration requires that all sections of a state be served. There are no precise figures on rural versus urban territory in accordance with the Census Bureau's practice of classifying as urban all places with 2,500 and more people. However, the Social Security Administration has published in the *Social Security Bulletin* for April, 1946, a special study of the "more rural" counties as compared with the metropolitan counties.[3] In June, 1945, the 2,800 counties which in 1940 were outside the metropolitan areas contained about one-half the estimated population 65 years of age and over in the continental United States. Yet in that month, those 2,800 counties aided about 59 per cent of all recipients of old-age assistance.

For each 1,000 aged persons in the estimated population in that month, 238 persons received assistance in nonmetropolitan counties; 197 persons received assistance in counties included in metropolitan districts having less than 500,000 population; and 160 persons received assistance in metropolitan counties of more than 500,000 population.

It is stated in the *Bulletin* that "the preponderance of recipients in the nonmetropolitan counties suggests that larger proportions of the population were needy." Several probable factors are noted: It may have been that residents in the metropolitan areas had more numerous opportunities for employment; also, in the larger cities, substantial numbers of aged persons and of children whose fathers had died were receiving benefits under federal Old-Age and Survivors Insurance, and consequently did not need to apply for public assistance. The *Bulletin* report further states that available studies of the incomes of beneficiaries of Old-Age and Survivors Insurance

in several cities revealed that the total income of most of these persons exceeded the usual standards for public assistance. Thus the concentration of Old-Age and Survivors Insurance benefits in the larger cities, among the workers in trade and industry, is one explanation for the concentration of payments for old-age assistance in the nonmetropolitan counties. In June, 1945, allowances were being paid to members of families of persons in the armed services in all areas. If these payments had not been made in the nonmetropolitan areas, the need for old-age assistance would probably have been greater than was indicated.

Average monthly payments for old-age assistance in June, 1945, were $37.38 in the larger metropolitan areas, $32.08 in the smaller metropolitan areas, and only $25.62 in the nonmetropolitan counties. Payments for general assistance or general relief averaged $37.60 in the larger metropolitan areas, $28.00 in the smaller metropolitan areas, and only $21.13 in the nonmetropolitan counties. The cost of shelter is generally recognized to be higher in the larger centers, but there is no accurate information on differentials in all living costs. Since general assistance is to help in providing relief in the minimum essentials of goods and services, these figures, like all other data, suggest altogether inadequate provision for financing of general assistance in the nonmetropolitan counties.

The large metropolitan areas, with only 29 per cent of the country's population, aided 41 per cent of all the general assistance cases reported, the study indicated further. The smaller metropolitan areas had 17 per cent of the population but only 14 per cent of the general assistance cases. The nonmetropolitan counties, with 48 per cent of the population, had only 40 per cent of the general assistance cases. (Certain "mixed counties" were omitted from the compilation.) General assistance cases usually include more persons per case in the nonmetropolitan counties than in the larger cities. And general assistance programs are solely dependent upon state and local resources. It is concluded that general assistance provisions are less in areas where economic capacity is relatively low but the number of needy persons "presumably high."

Incomes and Living Arrangements of Persons Aided. A special study initiated by the Social Security Administration gives important in-

formation on the incomes and living arrangements of recipients of old-age assistance in 21 states during the month of July, 1944.[4] The Bureau of Public Assistance developed a uniform plan for a study which was presented to the states as a voluntary project. In all 21 states but one, the study was made on a sample basis. In the 21 states, 900,000 persons received old-age assistance, and these were somewhat less than half of the total number of persons receiving aid in all states. The median age was 74.1 years. Slightly more than half of the recipients were women.

Fewer than one-sixth of these recipients lived on farms, and this was less than the proportion of the aged in the general population. The proportion of recipients on farms varied sharply, however, from 2 per cent in highly urban Rhode Island to 54 per cent in highly rural Mississippi. Almost 85 per cent of the recipients were able to care for themselves in the homes in which they lived. Only 3 per cent were actually bedridden, but an additional 13 per cent required considerable care from other persons. Three-fourths of the bedridden were cared for in their own homes, in homes of sons and daughters, or in other family homes.

Nearly 70 per cent of the recipients of old-age assistance lived in their own homes. Nearly 28 per cent lived alone in their own establishments. About 24 per cent lived with a spouse only. Less than 4 per cent lived in boarding or nursing homes or in private institutions. Almost 78 per cent of the spouses who were at least 65 years of age also received old-age assistance.

In drawing up the recipients' personal budgets, on the basis of which aid is given, state practices vary greatly, the report notes. The California law guarantees an income of at least $50 a month to recipients of old-age assistance. Although the assistance payment may not exceed $50 a month, persons may have "special needs" taken care of if they have income of their own. Varied practices are apparent in dealing with income in kind, which is very important to both village and farm residents. "Some states place a value on all such income and show this value on the resource side of the budget. Other states cancel out income in kind by leaving it out of the budget as a resource and omitting a corresponding item from the requirements. Such variation invalidates state comparison of total

needs when requirements of cases having income in kind are included."

About 27 per cent of the recipients had some small cash income —an average of $15.23 per month—in addition to public assistance. Only 14 per cent of the persons aided had as much as $10 cash income over and above the public grant. More than 40 per cent of the additional cash income came from earnings. The average "need" or "budget deficit" of the persons studied was $33.33 per month. The range of average budget deficit from state to state was $18.67 to $47.15. The highest average budget deficit for any group of recipients was that of $42.43 for those living in boarding or nursing homes or private institutions. In general, the average assistance payment was 94 per cent of the average budget deficit, or $31.45 per person. The average amount granted to persons living in institutions was $40.88, while those living with a son or daughter averaged $24.53, and those living alone received an average of $33.65.

Jane Hoey, director of the Bureau of Public Assistance, reported to the National Conference of Social Work in 1946 that "less than one-third of the states have established cost figures for fuel, light, water and shelter." Few "have decided what responsibility the agency has for . . . refrigeration, to replace worn-out household equipment and furnishings, to pay for insurance, medicine chest supplies, transportation." [5]

AID TO DEPENDENT CHILDREN

Much of the foregoing information about the structure of old-age assistance applies also to the federal-state program for dependent children. Some twenty-five years prior to the Social Security Act of 1935, the states had begun to provide widows' or mothers' aid allowances so that children who were left dependent could stay with their mothers. As we have noted in the preceding chapter, about half the rural counties that were permitted to make the provision never did so. Now, through the Social Security Administration, the federal government gives aid. The federal government sets a general pattern and shares the cost with those states and territories that have programs for aid to dependent children. Nearly all states have such programs. In 1936, the federal government paid as its share some

$26,000,000. In the year 1945, the federal funds amounted to over $71,000,000. In June, 1945, all jurisdictions but Nevada and Alaska received federal funds, and 648,800 children in 255,700 families were assisted, with an average payment from all federal, state, and local sources of about $47 per family. By August, 1947, more than 1,000,000 children in 400,000 families were receiving aid.

The state decides who is a dependent child, who shall receive aid, and how much shall be paid per family. State requirements differ, but in general the situation is as follows: Federal funds may be used to aid a dependent child up to the age of sixteen or to eighteen if he is in school. All states give assistance to children at least to the age of sixteen, and an increasing number are raising the age limit to eighteen. Usually federal grants may be used to aid children who are dependent because of the death of the father or the mother, sickness of either parent, or the continued absence from home of either parent. In this last category we meet the important social problems involved in divorce and desertion, and in a situation of a remarried mother of dependent children who has a second husband not legally responsible for support of children by her previous marriage.

Because the purpose of the program is to aid families taking care of their own children, allowances in which the federal government participates may not be given to children living in institutions. But assistance does not stop because of a temporary stay in a hospital. To receive federal aid, a child must live with his mother or some other near relative, including the father, brother, sister, grandparent, uncle, or aunt. Most states have similar provisions. A few states restrict more closely the relatives with whom the child may live. Most states require that a dependent child must have lived in the state for a certain length of time, generally for a year prior to the request for assistance. If a child is less than a year old, the mother may be required to have lived in the state during the year before his birth. No state may require more than one year of residence. No child may be refused aid because he has not lived for a certain time in one town or county.

Federal funds are granted to states for aid to children in need, but the states themselves decide how much property or other resources a family may have and still be in need. Usually, states con-

sider every kind of property and resource, including contributions from relatives if they are actually helping to support. By the terms of a 1946 amendment, the federal government may now share in a maximum payment of $24 for the first child and in one of $15 for each additional child, compared with the previous maxima of $18 and $12, respectively. (The states may add to these amounts whatever they wish.) The federal government may also pay higher proportions than previously. For dependent children the federal government will pay two-thirds of the first $9 per month for the first child and one-half of the federal maxima specified for succeeding children. A state making payments averaging less than $9 per dependent child will receive two-thirds of whatever it spends. If, however, the average payment per dependent child exceeds $9, the federal government will pay two-thirds of the first $9 plus half the balance, up to the specified maxima of $24 and $15. The federal government will also pay one-half of the "necessary and proper" costs of administration. On the basis of 1945 operations, the 1946 amendment increased annual federal payments by $26,440,000 over the $77,270,000 made available in that year.[6]

In June, 1945, the 2,800 nonmetropolitan counties, which had about one-half the estimated number of children under age 18 in the continental United States, were assisting 57 per cent of all recipients of aid to dependent children. The same factors that have concentrated need for old-age assistance in the nonmetropolitan counties apparently also operate to concentrate need for children in the more rural areas. The larger cities have more adequate general assistance and participate much more widely in the benefits of old-age and survivors' insurance than the nonmetropolitan counties. The average payment per family aided in June, 1945, from all sources was $64.89 in the larger metropolitan areas, $49.26 in the smaller metropolitan areas, and $38.32 in the nonmetropolitan counties. In the largest centers of population, the payment per family was thus almost twice as large as that in the nonmetropolitan counties.[7]

New Definitions of Child Aid. A reappraisal of the category of aid to dependent children had been made by Grace M. Marcus of the Bureau of Public Assistance.[8] In her opinion, the category is simply a sort of "middle ground" between a proposal for children's allow-

ances and one for a comprehensive general assistance program which would include the needs of families with children, whatever the cause for need. In the absence of more adequate programs, the category "has had some justification." But "this justification exists only as long as it is impossible to obtain a better provision." Experience indicates that the category is "fundamentally defective." In practice, the requirements of eligibility highlight conditions, "frequently arousing such strong suspicion and prejudice as to sidetrack concern for the child's need." The process of determining eligibility "has damaging personal and social connotations." In other words, a social stigma is often attached to the very conditions which must be used as categorical characteristics. Continued absence of a parent, for example, is one of the characteristics that determine eligibility. Also the phrase "physical or mental incapacity" is used.

There is in circulation a popular notion that "individuals deliberately leave home or cling to incapacity in order to obtain aid for dependent children." Miss Marcus does not subscribe to this widespread belief, but she nevertheless contends that there are "indirect effects of these eligibility conditions in situations in which the absence may not be necessarily final or the incapacity total or permanent." Also, a special category of assistance for children in their own homes both "affirms and denies the values and responsibilities of the parent-child relationship." It tends against direct recognition of the "right of the parent as the person responsible for the child." There is a further tendency to place the parent "in the position of intermediary between the agency and the child." Children living with their parents can be best served "through their parents and with their parents' wholehearted and voluntary support." The weight should be thrown toward treating the parent "as the responsible and determining agent."

AID TO THE NEEDY BLIND

The administrative arrangements for federal-state service to the needy blind are the same as for the two previous programs. It is recorded that a colonial government in America in 1696 made a public grant to a man stricken with blindness, for the rest of his natural life or until he might recover his eyesight. Public assistance

to the blind was authorized in Indiana in 1840, in New York in 1866, and in Ohio in 1896, but these laws were successively repealed. The first state to provide public aid for the blind in the twentieth century was Illinois in 1903. Massachusetts established a commission four years later.

In June, 1945, all states and territories except Alaska, Delaware, Missouri, Nevada, and Pennsylvania were receiving federal grants for aid to the blind. The total number of recipients of aid to the blind at that time was approximately 71,000, and the average monthly payment was $29.97. In the larger metropolitan areas the average payment was $36.66; in the smaller metropolitan areas it was $30.62; in the nonmetropolitan areas, $26.70. The 2,800 nonmetropolitan counties, which had about one-half the estimated population, aided about 53 per cent of all recipients of aid to the blind, indicating that the number of needy persons of this group are probably about evenly distributed between the more rural and the more populous areas of the country, even though the payments per person are larger in the bigger cities.

The requirements throughout the nation are usually as follows: To receive aid a person must either be totally blind or have such poor sight that he cannot earn a living. The individual states set the standards of what shall be considered blindness as a condition for receiving assistance. The federal law sets no age limit for aid to the needy blind. Several of the states also have no age requirements. Most states give aid under this program only to adults, and give care to blind children though other provisions of their laws. A few states set an upper age limit of 65 for aid to the blind, and then provide for needy blind people above this age through old-age assistance.

Only a few states require that a blind person must be a citizen in order to receive aid. No one who is a citizen may be refused aid for any reason connected with his citizenship—as, for example, that he has not been a citizen for a sufficiently long period. Many states do not require a definite number of years of residence, provided the person became blind while living in the state. Some require one year of state residence and a few a longer period. A cooperating state may not require more than five years' residence out of the nine

years prior to the application for aid, including one year just before requesting assistance. No one may be refused aid because he has not lived long enough in a specific town or county.

Federal money is granted to states only to provide for blind persons in their own homes, hence allowances in which the federal government participates may not be granted to persons living in public institutions, but a temporary stay in a hosptial will not stop aid. Each state decides how much property or other resources the aided person may have.

Twenty-five states have no statutory maximum payment for aid to the blind; eighteen have the federal matching maximum as their own; three have higher maxima than the federal figure; one will not permit payments as high as $40.

By the terms of the 1946 amendments to the Social Security Act, the federal government may now participate in the financing of a maximum grant of $45 instead of $40 a month, and the states may pay any amount above such maximum as they wish. The federal government may also pay two-thirds of the first $15 of the average monthly payment and one-half of the balance of payments that do not exceed the maximum. It is estimated on the basis of 1945 operations that the federal contributions will increase by some $3,313,000 annually over the $12,758,100 then expended for the year.

The national government through this program has singled out but one cause of total and frequently permanent disability for special grants, apparently without giving consideration to disabled persons as a whole.

Migration and Residence Requirements. Because of the unprecedented migration of the population in recent years, various residence requirements of the states have left gaps in the whole assistance program. Indeed, Arthur J. Altmeyer, administrator of the Social Security Administration, has written that "residence requirements for public assistance are an anachronism." He continues: "All proposals retaining residence requirements in public assistance are inconsistent with the goal of providing aid to all needy people.

"These requirements are time-consuming to apply and cause delay in making aid available. They are wasteful and administratively cumbersome. While every reduction in these requirements qualifies

some people who otherwise would not be eligible, some needy people still continue to be barred. The only way to qualify all otherwise needy people is to abolish all residence requirements completely." [9] In 1943, Rhode Island became the first state completely to abolish its settlement laws. The state, cities, and towns impose no settlement, residence, or citizenship restriction on eligibility for any type of public assistance.

Dilemmas and Issues in Local Administration. In a thorough paper on "Family Case Work and Public Assistance Policy," Gertrude Vaile refers to certain of the dilemmas faced by the social worker in the local office. Most writers, in considering the range and extent of case work service proper for a public assistance agency, limit responsibility to two aspects: (1) determination of eligibility and the amount of the relief to be granted, and (2) development of a "personal relationship." The first task may sound simple to lay people. Yet Miss Vaile points out, "It is astonishing how difficult it seems to be for even trained social workers to make a competent relief investigation." The development of a personal relationship aims to safeguard the client from injurious effects of dependency and to encourage independence. This, too, presupposes skill and experience on the part of the worker.

How much further does the responsibility of the trained worker go? Does it extend to "positive responsibility for family rehabilitation where needed and possible?" The New York State Public Welfare Law makes local welfare officials responsible for programs of relief, rehabilitation, and prevention. Miss Vaile contends that all these responsibilities should be carried out. She cites a fairly typical case in which public agencies were "bringing up eight children to what might fairly be described as chronic pauperism." The burden of hopeless dependency needs to be vigorously attacked, and this obviously cannot be done by routine investigations of eligibility for one form or another of public assistance. A thorough approach should include "persistent creative case work, whatever other means may also be needed."

When the social workers in many public offices are burdened under case loads of three hundred or more, how can they do anything but the routine essentials? Miss Vaile admits that this is a

difficult question but says there are important considerations that may help to answer it. Not all cases need special services. If responsibility for rehabilitation were clearly accepted as a necessary function, then the social workers at least could be "constantly on the lookout for possibilities in that direction." The skilled social worker has the responsibility of deciding whether or not further case work is needed in a particular instance. Unless rehabilitative case work is further done, so far as possible, there never will be the needed additional staff, and case loads will tend to increase.[10]

The Categories. The categories themselves present special problems. One farmer received in rapid succession every form of relief available, Miss Vaile recounts. He had had "work relief, general relief, drought relief, seed loan, medical relief, child welfare services, rural rehabilitation . . ." Each agency was in the county court house, and each took up this man with its own particular approach and closed his case by passing him on to another agency. The records were all in one building, but they remained "separate and unrelated." Finally the farmer was sent to the old-age assistance office and received aid, and his entire family tried to live from the small grant. Among all these workers, "nobody was *family* minded."

Because general assistance is inadequate, the workers try to put people into one of the categories. For one thing, general assistance is supported by local and state funds, and when people are put into one of the social security categories, the federal government pays part of the cost. But in actual experience, Miss Vaile goes on, although old-age assistance is based upon need, when granted it is widely looked upon as a pension. Finally, it is in the category of aid to dependent children that "we find the greatest problems of social policy that may affect the family." Here especially there is need for "case work practice upon the broader social problems of family life."

Another discriminating comment is from Marjorie J. Smith who concludes her study *Rural Case Work Services:*

Any program of public assistance must provide minimum financial security to all who need such help. But a truly adequate program will go one step further. Laws, administrative rules and regulations, must, of necessity, treat all alike. But there need be no limitation on the worker's

attitude of understanding and acceptance of the individual and his problems. The rights of individuals demand equal opportunities for services for all people, but the needs of human beings call for different treatment in each situation to meet individual problems. No two people have exactly the same difficulty. No two applications for Old Age Assistance, no two requests for Aid to Dependent Children, no two persons seeking work relief have identical problems. The case worker in the public agency must develop, to the highest degree, a sensitivity to differences in outwardly similar situations. Financial assistance must be given according to specified legal requirements, but the respect for and the acceptance of the person as an individual will determine what other services are made available to him.[11]

Local Participation. In 1944–45, the localities of the United States contributed about one-eighth of the total funds expended for old-age assistance, aid to dependent children, aid to the blind, and general assistance. The Bureau of Public Assistance, Social Security Board, reports that no local funds were used for old-age assistance in thirty states, aid to dependent children in twenty-three states, aid to the blind in thirty-one states, general assistance in five states, or for any of the four programs in six states.

State and Local Administration. In forty-two states, one state agency was responsible, in 1944–45, for old-age assistance, aid to dependent children, and aid to the blind. In twenty-five of these states, the same agency was responsible for general assistance.

In forty-two states, a single local agency in each locality handled all old-age assistance, aid to dependent children, and aid to the blind. In thirty of these states, the same local agency was also responsible for general assistance in some or all localities. (These are reports of the Bureau of Public Assistance, Social Security Board.)

Chapter 4 · OLD-AGE AND SURVIVORS' INSURANCE

THE ONE NATIONAL SYSTEM of social insurance is that named Old-Age and Survivors Insurance, established by the Social Security Act of 1935 and strengthened by the important amendments of 1939.[1] It was established to provide a monthly income for worker and family when the worker retires at the age of 65 or later and for his family when he dies. At present this national system is in operation for wage and salary earners in private trade and industry, and this includes many persons in rural communities. The jobs covered are, for example, those in factories, mills, mines, offices, stores, banks, garages, hotels, restaurants, and beauty parlors. Jobs not covered are, for example, all agricultural labor; domestic service in private homes; local, state, and federal governments; and nonprofit organizations—religious, educational, and charitable. Self-employed persons, such as men and women in small business, are also excluded.

This is a plan of social insurance to which both earners and employers covered pay compulsory contributions, collected like taxes by the Treasury Department and accounted for in the Old-Age and Survivors Insurance Trust Fund. There is no means test. Both employers and employees pay 1 per cent of wages up to $3,000 per person per year. Each of these rates is scheduled to advance to 1½ per cent in 1950 and to 2 per cent in 1952 and thereafter, but Congress has many times postponed scheduled advances in the rate of contribution.

When the plan had been in effect for ten years, over 74,000,000 persons had been covered by it. This was about 70 per cent of the population aged 14 and over. Some 8,200,000 persons had attained eligibility for permanent insurance. Nearly 3,000,000 new accounts were opened in the year 1946 alone. By October 31, 1946, total payments into the fund amounted to $8,825,700,000, and benefits paid out amounted to $1,239,100,000. Approximately 1,655,000 persons were receiving monthly benefit payments in 1946 at an average of about $20.

Once a worker has wage credits for forty quarters, equivalent to ten years of employment, he is regarded as permanently insured, even if he never again comes under the system. A worker may also become fully insured by working in covered employment approximately half the time between the beginning of the program on January 1, 1937 (or his twenty-first birthday if that came later), and the date of his sixty-fifth birthday or that of his death, whichever is earlier. He must also have been paid $50 in wages in covered employment in at least half of these quarters. A worker does not have to retire at the age of 65. A worker is regarded as "currently insured" if he worked in covered employment and received $50 or more in wages in six of the thirteen quarter years before he died. For widows and for children under age 18 surviving a "currently insured" worker, there are provided certain monthly benefits detailed below.

Retirement Benefits. The worker's benefits on retirement at age 65 or after are based upon average monthly wages up to $250 per month. The benefit is figured by taking 40 per cent of the first $50 of his average monthly wage, and adding 10 per cent of the next $200. This is called the "primary" or "basic" benefit. Then 1 per cent of this total is added for each year in which he was paid $200 or more in covered employment. The total payment is not less than $10 a month. A wife also receives a monthly retirement benefit when she reaches age 65, equivalent to one-half the worker's benefit, and payments of this amount are also made to unmarried children of retired workers until they reach age 16, or 18 if they are in school. A worker's retirement benefit and the benefits of his wife and children are suspended for any month during which he earns more than $14.99 per month in a covered job. A beneficiary may go on and off the benefit rolls as circumstances, health, and jobs permit. He may work on a job not covered by Old-Age and Survivors Insurance, or he may run a business of his own, and continue to receive his insurance benefits, no matter what his income. Benefits are discontinued for a woman when she remarries or becomes divorced, unless she had earned benefits through her own employment. A child's benefits end when he leaves school (if he is over 16), is adopted, or gets married.

An illustration of a retirement benefit for a worker, fully insured on reaching age 65, after having an average monthly wage of $150 for nine years, and that of his wife, aged 65 or over, is furnished by the Social Security Administration:

Take:	
40 per cent of the first $50	$20.00
10 per cent of the rest ($100)	10.00
Your basic benefit is	$30.00
Add 1 per cent of $30 for each year (or 9 per cent)	2.70
Your monthly benefit is	$32.70
Your wife's benefit (one half of yours)	16.35
Together you get, monthly	$49.05

The total monthly benefits that may be paid on account of one worker may not be more than twice the basic benefit, or 80 per cent of the worker's "average monthly wage," or $85, whichever is least.

On death, a lump sum benefit is paid which amounts to six times the monthly benefit to which the worker would have been entitled (whether fully or currently insured). It may go to the surviving spouse. However, when it is paid not to a survivor but in reimbursement of those who paid funeral expenses, it may not exceed the amount actually paid for the funeral, which may be less than six times his monthly benefit.

Survivors' Benefits. Monthly benefits are payable to the following survivors of "fully insured" workers, no matter at what age the worker dies:

His unmarried children under age 18;

His widow of any age while she has children in her care who are entitled to benefits;

His widow when she reaches the age of 65;

His chiefly dependent parents, if the worker leaves neither children nor widow.

Even when the worker dies currently insured, that is, if he worked in a covered job approximately half the last three years of his life, monthly benefits are paid to his children under age 18 and to his widow if she has such children in her care.

Survivors' benefits are suspended for any month in which the person receiving the benefit earns more than $14.99 in covered employment. This means that a child's benefits will continue even if the mother earns more than $14.99 a month in a covered job, and that a widow's benefit continues even when her child earns more than this sum in covered employment.

An illustration furnished by the Social Security Administration shows the benefits payable to the survivors of a worker who died insured after having had an average monthly income of $150 a month, as in the case above:

Widow at 65 (¾ of $32.70; see above)	$24.53
Widow with children (¾ of $32.70)	$24.53
Each child (½ of $32.70)	$16.35
Or, each aged, chiefly dependent parent (½ of $32.70)	$16.35

Such payments are made every month to eligible persons.

Recapitulation of Rights to Benefits through Insurance. When an insured worker dies, whatever his age, monthly payments may go to his children and to his widow with such children in her care. The widow's benefit continues until her youngest child reaches 18. If a mother who is herself a wage earner dies, the children may receive benefits just as in the case of a father's death. The benefits are based upon the worker's wages.

When an insured wage earner reaches 65 and retires, benefits are payable to the worker himself, his widow after age 65, and his children under 18. The amount of payments to a wage earner's dependents is based on his own benefit rate. A widow's payment equals three-fourths and each child's equals one-half, with the same limitations as those described above for survivors' benefits.

Payments to Rural Residents. Payments of benefits to older persons who had retired and for widows' current benefits in June, 1945, went largely to persons in the metropolitan counties.[2] These persons received 63.5 per cent of the total payments for retirement benefits, compared with 28.7 per cent for the 2,800 nonmetropolitan counties. Certain "mixed counties" were excluded from the tabulation. The metropolitan counties also received 61.3 per cent of widows' current benefits, compared with 31.3 per cent for the nonmetropol-

itan counties, although the latter had about 50 per cent of the total estimated population under age 18 and over age 65. The explanation is, of course, that agricultural vocations are not covered, and only rural people in trade and industry are included.

Benefits to Survivors of Deceased Veterans. The 1946 amendments to the Social Security Act provided for monthly benefit payments to survivors of veterans of World War II, even if the veterans never were engaged in covered employment.[3] It is expected that the survivors of from 100,000 to 150,000 veterans may receive monthly payments. Benefits are available to survivors of certain veterans who die after discharge. These will be paid to many widows and children of the deceased veterans who were engaged in agriculture.

In general, the law now guarantees certain survivors of veterans the same old-age and survivors' benefit rights they would have enjoyed had the veterans died fully insured with not less than $160 a month of average wages and a year of coverage (in addition to years of coverage otherwise earned) for each calendar year in which they had thirty days of military service after September 16, 1940. However, the guaranteed, insured status will not be available when the survivors are found to be entitled to pensions or compensation from the Veterans Administration or when a serviceman died in active service (in case of re-enlistment). Survivors' benefits based on covered employment before or after the veterans' military service are not affected.

The purpose of the measure is to close the gap in protection for the families of veterans in the event of their death between the time of service discharge and the date on which they might be expected to acquire or re-establish protection through civilian employment covered by Old-Age and Survivors Insurance. The total costs of the program are expected to amount to $175,000,000 from 1946 through 1959.

Survivors qualify if the deceased veteran:

1. Had been discharged from the armed services under circumstances other than dishonorable within four years and a day after the officially proclaimed end of World War II. (As this is written, the official end of the war has not been proclaimed.)

2. Had at least ninety days of active duty between September 16,

1940, and the official end of the war. The ninety-day requirement does not apply if the veteran was discharged because of physical disability incurred or aggravated while in service.

3. Died within three years of the date of his discharge.

Survivors of deceased veterans who may qualify are:

1. Widows of any age with young dependent children in their care. They will receive monthly benefits until they remarry or until the youngest child reaches age 18. If the widow does not remarry, she may file again for benefits at age 65.

2. Widows aged 65 or over. They will receive monthly benefits for life or until they remarry.

3. Young dependent children. They will receive benefits until they are 18 years old or until they marry.

4. Aged parents dependent upon the deceased veteran who leaves no widow or child under 18. Their benefits will continue for life or until the parent remarries.

Lump sum payments will amount to $187.86 if the veteran had one year of service, and $195.30 if there were five years of service. Monthly benefit payments to a qualified widow will be $23.48 if the veteran had one year of service, and $24.41 if the veteran served five years. A widow and two children will receive amounts varying according to years of service from $54.79 to $56.96.

An Incomplete System. Obviously, the system of Old-Age and Survivors Insurance is not a complete one, and private industry has maintained and even expanded its private pension plans. Apparently the managers of industry regard Old-Age and Survivors Insurance as simply a national subsistence plan and private plans as necessary supplements. Rapid advances in living costs between 1937, when the system began, and 1948 have considerably reduced the purchasing power of available benefits. Among the large gaps are these: No provision is made for benefits to persons who are forced to retire on account of disability prior to attaining age 65, whether insured or not. There is no provision for many persons who shift from covered employment before attaining insured status and are unable to return to jobs included in the system. There is no provision for the widow under age 65 who does not have the care of a child, under age 18, of the deceased worker. The exclusion of social welfare

workers and of employees of churches and educational organizations and institutions is frequently noted. Many of these persons are not covered by private plans. Many workers in nonprofit agencies should have the protection of both public and private plans to the same extent as large numbers of workers in trade and industry, because their needs on reaching age 65 are usually no different from those of other employed persons.

Social Security for Farm People. There appears to be general agreement that the present social insurance provisions do not meet the needs of farm groups. Farm people can qualify only by working in trade and industry "off the farm." It appears that a considerable number now have some credits, but to achieve the forty quarters or ten years of employment required for fully insured status may be very difficult even for those who have occasional industrial employment. A sample study by the Social Security Administration and the Farm Security Administration revealed that only 18 per cent of the farmers in Arkansas and 6 per cent in Iowa had any earned credits to their social security wage records by the end of 1940. Sample studies also reveal that farm families carry relatively little private life-insurance protection. In 1935–36, according to the study of consumer incomes and expenditures made by the National Resources Committee, only 38 per cent of the white farm families with net incomes below $1,500 carried life insurance. And the average yearly payment of premium by those having insurance was only $64.42 per family. Therefore, extension of Old-Age and Survivors Insurance to the farm population is widely recommended.

Chapter 5 · FEDERAL-STATE SOCIAL AND HEALTH SERVICES

CHILD WELFARE

THE REQUEST for aid of the state public welfare department came from a county Parent-Teacher Association. It was apparently the one group most conscious of the need for special children's services under professional direction. The state representative worked with this group for two years. Then the Association called a county-wide meeting which resulted in a specific request to the state office for the service. The executive committee of the P.-T.A. became the nucleus of an advisory committee. Other members were the judge of the juvenile court, the county superintendent of schools, and the director of the county public assistance office. This local group felt an interest in and responsibility for the program, Mildred Arnold, director of social services of the Children's Bureau, relates.[1]

The child welfare worker who was employed began to learn about the county from the small advisory group and from day-to-day contacts with many others. The county was regarded as "entirely rural." It had a total population of less than 10,000 people. It had poor soil, and getting a living from the soil was a constant struggle. Despite this, the county never had had any public debt. The number of persons receiving public assistance was relatively low. The county was independent—it had refused to cooperate with the Federal Emergency Relief Administration in 1933–35 because to receive funds involved outside supervision, which was not welcome. Only a year before the rural child welfare worker came, the county officials had refused an offer from the state board of health to pay $2,000 for the support of a public health nurse if the county would put up but $500. Most of the citizens appeared to support such policies.

Rifts between churches, and between groups within churches, were reported to the new child worker. Opinion in the churches tended to limit the voluntary recreational programs of schools and

churches. One result was that many of the young people were opposed to these restrictions and were going in large numbers to taverns and dance halls. The county had had almost no professional social work service. With this as the background, the county worker began to explain the kind of services she was prepared to render.

The advisory group discussed "foster homes, adoption, or work with unmarried parents and the child born out of wedlock," all services on behalf of socially handicapped persons in this rural county. The professional worker told the group how she went about to look for a foster home. A state consultant on adoptions helped. The worker called on ministers, physicians, and school principals. One child remarked to her mother, who was separated from the father and was having difficulty in maintaining a home, "Let's talk to Miss —— first [mentioning the child welfare worker]. I heard her talk at school, and she cares about what happens to children." It turned out that "service rendered in individual situations was the most effective means of interpretation," Miss Arnold relates. "In a rural area, far more than in an urban one, the citizenry generally are aware of families receiving service." After two and a half years of preliminary demonstration work, the governing board of the county took favorable action to have the services continued. The local people had recognized the need and the value of the services in meeting the need, and they had assumed responsibility.

The county is one of about five hundred in which child welfare services of this type are maintained. This means, however, that five out of six counties do not yet have the programs. This federal-state program was initiated by the Social Security Act of 1935. Federal funds do not need to be matched by the states, but *part* of the cost of the services provided must come from state or local funds. The Children's Bureau administers the funds. By a 1946 amendment, the federal appropriation totals $3,500,000 a year, compared with only $1,500,000 previously. The Bureau is directed by law to grant a minimum of $20,000 to each state, and to apportion the remainder according to the relation of the state's rural population to the rural population of the United States. For in 1935 it was provided by law to make this service available in areas predominantly rural and also other areas in special need. The funds must be used for services.[2]

Examples of apportionments of federal funds in 1946 were: Texas, $165,363; North Carolina, $127,722; Alabama, $102,028; Georgia, $105,053; New York, $115,980; Pennsylvania, $157,472. It was expected that with increased federal funds, there could be a marked expansion of the services for neglected, dependent, and delinquent children and others requiring special help. The states themselves decide how the funds are spent, but it is expected that, as previously, most of the money will go to provide salaries for full-time child welfare workers. They will find foster homes for children needing day care; assist with services for orphans and the wards of the courts, and unmarried mothers and children born out of wedlock; and give guidance to children with behavior problems and those who are mentally handicapped. The Children's Bureau has found that outside of metropolitan areas relatively few welfare workers are locally provided; hence the need for funds in the more rural counties.

When the Social Security Act was passed in 1935, there were eleven states which had made no provision for general state-wide services for children of the types enumerated. In two states, a child welfare division in the state public welfare department had just been organized. In ten states there were limited child welfare services but no divisions giving special emphasis and supervision to child welfare programs. In twenty-five states child welfare divisions within the state departments administered public welfare programs. The programs in the states which had made provision varied considerably. In general, local services for children in the rural areas in 1935 were limited to juvenile court procedures, relief, mothers' allowances, and foster care either in family homes or in institutions.

State Cooperation. All the states cooperate. The federal funds have enabled the states to establish, extend, and strengthen services and to assist local communities in selected areas. Neither the language of the act nor the amount of the appropriation called for complete coverage of all rural areas on an equal basis. The Children's Bureau knew in 1935 that there were neglected, handicapped children on the prairies and elsewhere in rural areas. The staff of the Bureau also knew that they were to use the funds by allotment to the states on

the basis of plans to be developed jointly by the cooperating state welfare agencies and the Bureau.

First a philosophy of a national program was worked out. Child welfare services for these rural areas, it was decided, must be carried on as an integral part of the total child welfare program within a state rather than as an isolated and unrelated service. It was also decided that the services rendered must include prevention. To limit activities to treatment after a child's own home had failed him and provision had to be made for him to live elsewhere was recognized as inadequate. The workers must attempt to work with children before tragedies occurred and to cooperate with individuals and organizations in developing social resources to prevent neglect, and delinquency of children.

Experience has demonstrated amply that remote control is ineffective as a method of either protection or prevention. When tragedy comes, the state itself or certain social forces of the community may be roused to action, but often it is then too late for fruitful local procedures. Therefore the administration of this law aims toward the development of resources for the care and protection of children where they live, toward making this service an integral part of the local public welfare unit where one exists. State programs are required by the Bureau to be consistent with the provisions of the Act, but they are obviously not uniform.

Extent of the Program. By June 30, 1940, there were 735 professional workers whose salaries were paid in whole or in part from federal funds. Of these, 495 were rendering direct services in local communities, and 240 were attached to state staffs. These latter were engaged in organizing and demonstrating child welfare service, consulting with the local workers, and rendering specialized services related to the development of adequate care and protection for children. Of the 495 workers in local areas, 445 were serving 512 counties, 11 were serving areas composed of a combination of towns or other local areas, and 39 were giving some case-work services to children in larger districts, covering 652 counties as a part of their work of developing interest in the employment of local child

welfare workers. In addition, the 240 persons on state staffs occasionally reached a large number of communities in other areas.

In most states the emphasis has been on full-time service in county units by workers specializing on child welfare problems. Of the 512 counties receiving services through federal funds in 1940, 486 were in the continental United States and were classified as "rural." Of these 486 counties, 299 were organized in one-county units, and 187 were in one- to four-county units. (During the war years there was no substantial change in the extent of the work.) During 1940, 41,109 children in 20,104 homes received care. Of these 41,109 children, 31,277 received services in their own homes, 9,324 received foster care, and 508 all other services. In that year, available figures indicated that about 60 per cent of the children receiving child welfare services were in homes that were also receiving some form of public assistance.

Child welfare workers in rural areas have been successful in expanding case-work service in rural areas, but as yet relatively few rural counties are willing to commit themselves to support such a program. There are other rural aspects of the enterprise that create special problems. In some states, adoption is not regulated by law. Fine babies need homes, and good people want children. People tend to feel that adoption will take care of itself. Yet in actual practice, as Ruth Cary Aleshire has pointed out, many rural areas lack the resources which are necessary to carry through satisfactory adoptive placements.[3] In rural areas especially, there is a problem of keeping data confidential, when a good deal about a situation is known and discussed within a wide radius. It has been a tradition that judges, doctors, ministers, and others help, and in rural America particularly, placement is accompanied by much personal knowledge. How can a professional local worker who is a part of a community become helpful and improve procedures? The task is never easy. The social agency has to demonstrate that it has a more significant contribution to make than the untrained persons who have personal interest in the problems and who have helped to the best of their ability.

Thirty states provide for some social investigation of petitions for adoption, and sixteen states require a recommendation from the

state public welfare department with respect to the desirability of the adoption. But only five of these sixteen are among the states which had the highest proportion of rural population in 1940. Thus the more rural states have the least adequate provisions.

Specialists in this field recommend more adequate provisions to protect the rights of inheritance of adopted children. They recommend that birth certificates be issued which do not reveal illegitimacy. It is reported by the Bureau of the Census that a new type of birth card is now in legal use in Mississippi, Ohio, Oregon, Tennessee, and Washington. The card certifies name, race, sex, date and place of birth, without indicating illegitimacy.

Expansion of child welfare services of the type considered above is widely recommended. Experimentation and demonstration in the 500 counties where the services are maintained has shown that organized society has failed large numbers of rural children by not providing for them after their own homes have failed them. Existing rural institutions cannot provide the special services required by children in special need. There is increasing demand that public resources be forthcoming for them.

Milestones. The four national White House conferences on care of children, held decennially, have had a marked influence upon the development of programs for children. Plans are being made for holding one again in 1950. At these conferences, persons most concerned have come together, formulated their convictions in the form of recommendations, and then worked to implement their suggestions. States also have held conferences. Of the recommendations of the 1940 Conference on Children in a Democracy, the Report Committee wrote that "they offer a practicable and . . . adequate program of activities for the well-being of the children of America."

The economic reports and investigations of the Children's Bureau have brought together factual information with respect to child labor and other conditions which is not available from other sources. These studies have provided factual bases for needs. They have frequently had public attention. They have illustrated the function of social research in the processes of social education and action.

MATERNAL AND CHILD HEALTH

The Social Security Act of 1935 emphasizes the need for provisions "enabling each state to extend and improve, as far as practicable under the conditions in such state, services for promoting the health of mothers and children" and adds that such provisions are called for "especially in rural areas and in areas suffering from severe economic distress." In 1946, the annual federal grants for maternal and child health were increased from $5,820,000 to $11,000,000. Services are in operation in all the states. Grants are made by the Children's Bureau to state departments of health. One-half of the $11,000,000 granted to states must be matched by them. From the matched funds, each cooperating state receives an assured minimum of $35,000 a year, and the remainder is allotted in the same proportion that the number of live births in each state bears to the live births in the United States. The unmatched portion, $5,500,000, is apportioned on the basis of the state's financial need in providing services in accord with plans worked out with the Children's Bureau. An amendment of 1939 provides that each cooperating state shall establish and maintain a merit system for the selection and retention of employees included in any plan.

Location of Programs. These state programs for promoting the health of mothers and children are thus concentrated at points of special need. Each cooperating state health department or board has set up or expanded a maternal and child health division under the direction of a physician. Because clinics are an important part of the programs, previous clinical experience has been considered by most states as a prerequisite for a director. It also has been thought essential to have on each state staff a public health nurse to serve as the chief advisory nurse, and another to serve as a special consultant on maternal and child health nursing in the state's division of public health nursing.[4]

By June 30, 1939, the state plans had provided for 71 full-time and 8 part-time physicians; for 541 public health nurses to serve in an administrative, consultative, or supervisory capacity; for 43 nutritionists in twenty-four states; for 34 health educators in twenty

states; for 67 dentists in twenty-nine states; and for 52 dental hygienists in thirteen states. The workers in the maternal and child health division usually cooperate with other divisions of the state health department, with the state education department, and with voluntary agencies. It is customary to organize state advisory committees. Numerous demonstration projects have been carried out in connection with state plans. Part of the federal-state funds are used to build up maternal and child health service in local areas, especially in rural counties. The county health officer in an organized public health unit is responsible for development of the maternal and child health program as a major feature of the local program.

Illustrations of Types of Service. Services already were widely extended by 1939. It was known that adequate medical and public health nursing, started early in pregnancy, would increase the probability of safe delivery for the mother and of health for the baby. The prenatal clinic or conference conducted by a physician, supplemented by the educational services of the public health nurse in the conference, in home visits, and in group instruction, is the form of service generally regarded as necessary for many women unable to obtain such prenatal care elsewhere. By June 30, 1939, 1,299 maternity centers were in operation in 34 states. Here monthly conferences were held, and physicians gave prenatal and postnatal service to mothers as part of the maternal and child health program supervised by the state health department. About 19 per cent of the counties of the United States reported such centers. The states also reported that prenatal and postnatal services to mothers were being given by public health nurses through home visits in 1,918 counties, or 62 per cent. Such services were reported in every county in 12 states. These services were rendered for the most part in the smaller towns and rural areas. (In the larger cities the municipal health departments provide extensive prenatal and postnatal services for mothers.)

As a means of improving maternal care, the state departments were beginning to employ on a full-time basis expert obstetricians, who visited prenatal clinics and advised with local physicians conducting the clinics and also rendered clinical consultation when

necessary. The training of midwives has been encouraged. The untrained midwife is a significant factor in health service in many states. In one state, 50 per cent of the births were attended by untrained midwives. The untrained midwife is, however, a symbol of an economic level at which the cost of physicians' services is largely prohibitive. Improved supervision over midwives has been developed slowly. Several states have employed public health nurses with midwife training to give local public health nurses advice on how to supervise midwives. In a few counties, midwives who have become public health nurses are employed by the counties to give supervision at the bedside when the midwife is conducting the delivery.

As prenatal programs gradually developed, the need for providing better care for mothers became increasingly apparent. Public funds for such care have been available only in small amounts. But state health agencies have undertaken demonstration projects in providing various types of care at the time of delivery for mothers unable to obtain such care otherwise. By June 30, 1939, home delivery nursing service was established in 102 counties in 35 states, and in that year a total of 16,823 mothers were given nursing service at the time of delivery.

The Child Hygiene Movement. The child hygiene movement has been greatly extended by this federal-state program. One important device is the child health conference. During the year ending on June 30, 1939, state health agencies in 36 states reported the establishment of 522 child health centers at which conferences were held at least once a month, making a total, with those already existing, of 2,394 such centers at which monthly meetings were held. In that fiscal year, 33 states employed practicing physicians to conduct child health conferences, and in 16 states practicing dentists were employed to assist in conducting the conferences. The child health conference requires careful planning. The presiding physician should know the fundamentals of pediatrics and his knowledge should include nutrition and mental hygiene if he is to be equipped to build the type of health supervision that helps a child to realize his own potentialities. Of equal importance is the physician's interest and skill in teaching mothers; the knowledge made available in

the conference is directed toward the mothers, who, it is hoped, will apply it and disseminate it. The services of the public health nurse are also indispensable. (See Chapter 14, the section on "Public Health Nursing.")

Extent of Program. The number of counties in the United States in which health services for mothers and children were provided under the supervision of state health agencies in the year ending June 30, 1942, was as follows, with reporting incomplete for one state:[5]

Services	*Counties*
Prenatal clinics conducted by physicians at least monthly	789
Child health conferences conducted by physicians at least monthly	1,047
Examination of school children	1,399
Public health nursing service which includes services for mothers and children	2,199
Corrective dental services	
Maternity	175
Preschool	386
School	633
Home delivery nursing services	170

During the war years 1943–45, the program was much affected by the entrance of physicians and nurses into the armed services. The problems generally became those of replacing personnel and readjusting programs to make it possible for limited staffs to carry on. There were necessarily reductions in service. However, with the larger federal appropriations of 1946 and the return of medical workers from the armed services, it was expected that there could be considerable expansion. It was announced in 1946 that much of the new money probably would be used to extend facilities to reduce the mortality rate of prematurely born babies, to provide more physical and dental examinations for school children, and to expand the meager beginnings in mental health by establishing more guidance clinics. Several new maternity care demonstration projects are to be established, of which the one at Tuskegee, Alabama, is an instance. The purpose is to show by example what might be done in providing comprehensive maternity care to a group of women

who now often lack even the most elementary care. The Advisory Committee of the Children's Bureau has also recommended establishment of blood banks at strategic centers for saving lives of mothers needing transfusions, provision of chest X-ray examinations of all maternity patients, and grants of fellowships in mental health to teachers in order to offer extended mental health services.

For the year 1947, it was announced by the responsible state agencies that there would be a total of about $16,000,000 of federal, state, and local government funds for maternal and child health programs. More than 50 per cent of the total funds were to be used by local health agencies. The communities where most of the services were being provided were in rural areas. Only a relatively small percentage of the funds were used in counties that had a city of more than 100,000 population. Preliminary estimates indicated that about $1,000,000 would be used to pay physicians, dentists, and hospitals for services to mothers and children. These programs are obviously not the total of maternal and child health services. In every state, both public and private agencies provided certain services in addition to those available through agencies that received federal funds.

It is evident that in large rural areas no major steps have yet been taken to meet the needs listed above by the methods outlined and that public funds are needed in still greater measure.

CRIPPLED CHILDREN

Congress again stressed aid "especially in rural areas and in areas suffering from severe economic distress" when it provided, in the Social Security Act of 1935, for assistance to the states to enable them to extend and improve services to crippled children. More specifically, the act calls for provision of services for "locating crippled children, and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and after care, for children who are crippled or who are suffering from conditions which lead to crippling."

In 1946, Congress appropriated $7,500,000 for grants-in-aid to the states to carry out the above purposes, compared with $3,870,000 previously appropriated. Cooperating states must match half of the total federal fund. The sum of $30,000 is granted to each cooperating

state, and the remainder is allotted according to the need of the state, after taking into consideration the number of crippled children requiring care and the cost of providing such care. The federal-state programs have been in operation in all the states. Federal grants usually are made to the state health departments. The Children's Bureau administers the federal program and approves plans of cooperating states.[6]

The Register. In order to locate the crippled children requiring care, each cooperating state has set up a register. On June 30, 1944, the registers in all the states included the names of 373,177 crippled children. The children registered are those under 21 years of age who are living in the state or territory and who are suffering from crippling conditions as determined by the diagnosis of a licensed physician under the definition given in the state law. Included are children under care or awaiting care by the official agency for crippled children or under other public or private auspices. About 97 per cent of the children registered are suffering from conditions calling for orthopedic or plastic treatment, and only 3 per cent from other types of crippling conditions.

How Care Is Obtained. The parents or friends of a crippled child who needs care that his family cannot provide report the child's name to the state crippled children's agency. Children needing care are also reported to the state agency by physicians, public health nurses, social workers, school officials, and other individuals or groups who are helping to locate crippled children. After receiving the name, the state agency then arranges, as soon as possible, for a diagnosis of the child's condition at a crippled children's clinic.

The purposes of the program are to assure for every child served the maximum physical restoration possible, to aid him in adjusting to life at home and in the community, and to enable him to take advantage of opportunities for education and vocational training. If on the basis of the diagnosis hospital treatment is regarded as necessary, the state agency arranges for the child's admission to an approved hospital as near his home as possible, where appropriate medical and surgical treatment are provided. The state crippled children's agency pays for medical and surgical treatment and for

hospital and convalescent care. After the child leaves the hospital, medical treatment and other aftercare services are provided as needed in the child's own home, a convalescent home, or in a foster home.

Summary of Services Provided. During the year ended June 30, 1944, the following services for crippled children were reported by state agencies; to the Children's Bureau: [7]

Visits to diagnostic and treatment clinics for medical service	183,086
Children under care in hospital, including readmissions	31,428
Days of care provided in hospitals	1,228,158
Children under care in convalescent homes, including readmissions	5,660
Days of care provided in convalescent homes	444,776
Children under care in foster homes	1,190
Days of care provided in foster homes	92,438
Visits by public health nurses	158,661
Visits by physical therapists	176,744
Children given medical-social service	21,841
Children referred for vocational rehabilitation	5,952

By 1934, 35 states had made some provision for services. The first state-wide program was that of Ohio in 1919. The first public hospital for care of crippled children had been established in Minnesota in 1897. Private organizations have also been active in maintaining hospitals, raising funds for care, and expressing an interest in the standards of care. At the time of the enactment of the Social Security law in 1935, relatively few states had a state-wide program, however, and in several of the states the appropriations were so small that only a few children could be cared for annually. Thus the federal-state program has enabled the states to carry out more adequate programs than previously.

Provisions for Education and Prevention. Certain of the states have funds, administered by the state department of education, which are made available for covering the costs of special education for crippled children. Such costs include transportation to school, special

equipment to aid children in participating in physical education, and special teaching services for crippled children in hospitals. Efforts are being made to expand these state funds.

When a crippled child becomes 16 years of age, he may apply for vocational training, available from funds provided jointly by the state and federal governments for the vocational rehabilitation of the physically handicapped. Provision is also made in a number of states for vocational guidance to crippled children who are under 16. The federal grants for vocational rehabilitation are made to enable the states to meet the needs of physically disabled civilians of employable age. They are administered by the Office of Vocational Rehabilitation of the Federal Security Agency. Corrective medical services and hospital care were authorized in 1943, in addition to vocational education and training. In the states, the vocational-rehabilitation service is associated with the department of public education. Agreements have been made by the Federal Board for Vocational Education and the Division of Health Services of the Children's Bureau to the effect that state educational agencies shall refer to the state crippled children's agencies all persons under 21 years of age who have crippling conditions for which treatment may be provided under the crippled children's programs.

Every year the advance of medical science makes possible new methods for the prevention of crippling conditions. An example is the use of penicillin in reducing the crippling effects from osteomyelitis. Better obstetric care reduces birth injuries. Proper nutrition prevents rickets. Reduction of frequency of accidents will prevent many crippling effects. The public has been made aware of the need for prompt care in cases of infantile paralysis. Prevention of tuberculosis reduces the incidence of crippling conditions in bones and joints. Prevention is an integral part of the federal-state program.

Children with Rheumatic Fever and Heart Disease. No definition of a "crippled child" has ever been given by the Children's Bureau. During the early years of the program, the states gave major attention to persons requiring orthopedic and plastic treatment. There has been a growing interest in helping children with rheumatic

fever and heart disease, and in 1939, Congress authorized an increase in the federal appropriation with the understanding that part of the new funds would be used to meet the needs of such children. By 1944, seventeen states had approved programs for the care of children with rheumatic fever and heart disease.[8] The state agency administering the program is the same as that responsible for the crippled children. All the state programs emphasize care of children with rheumatic fever or rheumatic heart disease, but certain children with other forms of heart disease also may be assisted.

Future Plans. When the increased federal appropriations were made in 1946 there were on state registers about 20,000 deformed children whom the states were not able to aid, and it was expected that new funds would go to meet the immediate needs of such children waiting for services. Advisory specialists recommended to the Children's Bureau that systems of care should be expanded for persons who were victims of fever, of speech and hearing defects, and of epilepsy and chronic illness, as well as the orthopedically handicapped, and that provisions for those with rheumatic fever should be expanded.

Chapter 6 · RED CROSS PROGRAMS

In 1946 the White River in the state of Washington overflowed its banks, and a thousand families were driven from their village homes and farms. There were no deaths, but damage to farms and homes was put at a figure near $1,000,000. Military rescue crews stood by with "ducks," skiffs, and other boats. The Red Cross Disaster Committee went into action. This is but one recent illustration. In the year 1944–45, $2,900,000 was expended on 260 "disaster operations." The American National Red Cross annual report for 1945 said that "spring floods and tornados are as much a sign of spring in some parts of the country as daffodils are in others." [1] In 1947, the United States experienced the most destructive disasters in its history. The Red Cross gave aid in 267 of these.

Disaster Operations. One of the chief functions of the Red Cross in a disaster operation is "to coordinate the efforts of agencies and individuals into a total relief plan." At its call, a nearby army camp may send boats or rescue equipment or pontoon bridges to evacuate families marooned by flood. The state welfare department may loan mattresses, comfortables, and stoves for use in shelters. Often several temporary shelters are needed. The Red Cross accepts gratefully the offers of help that come from all directions and tries to make good use of all volunteers.

Medical aid stations must be set up to provide dressings for minor injuries. An inquiry service takes care of the innumerable questions that pour in from anxious relatives and friends. Shelters are kept open, as the disaster victims take stock of their losses and their remaining assets. The next step is to encourage families to marshal their resources. If there is a gap between family needs and family resources, the Red Cross steps in to assist further.

An advisory committee in the jurisdiction of the local chapter, with knowledge of local conditions, considers requests for grants carefully. If financial aid is needed to pay hospital or doctors' bills, to rebuild or repair homes, barns, garages, or other buildings, to

replace or rebuild furniture or household equipment or other property, a grant usually is made. The local chapter, usually covering a single county, is the local unit of the Red Cross and is responsible for Red Cross activities and services within its territory, subject to the policies and rules of the national organization. The annual report explains that to families aided in time of disaster the Red Cross says, in effect, "This is a gift, not a loan. Use it to get back on your feet and make a fresh start. Good luck. And don't thank us, thank the American people."

The Rural Chapters. The rural chapters are those that operate in counties which have no city with a population over 10,000. There were 2,908 such chapters in 1947. These are the units that work with and in the small communities and the open country, and the overwhelming majority of those who serve in them are volunteers. In numbers, these 2,908 chapters constitute more than three-fourths of all the chapters. There is a board for each chapter, composed of a group of citizens, drawn from the several sections of the county, who work without compensation. This group gives general direction to the program.

The functions vary considerably, according to reports. When a cyclone blew away the chimney of a farmhouse in a small Colorado community, the owner's first thought was to call the Red Cross. The chapter chairman, a hardware dealer by trade, drove to the farm, and he and the farmer rebuilt the chimney. There is also a local chairman in Georgia who uses his personal airplane to deliver emergency welfare messages to people in remote areas when roads became impassable. These are not within the realm of normal chapter activity, Donald Goldthorpe writes in an article on the rural chapters, but they illustrate the mode of service, the way the people go "all out" for the people.[2]

Home Service. In the rural chapters in 1946, 7,000 volunteers were actively engaged in home service operations, compared with 2,100 paid workers—a ratio of more than three to one. In the year ending March, 1946, these home service workers carried out the primary responsibilities of the Red Cross to members of the armed services, veterans, and their dependents, by supplying financial assistance of

over $15,500,000 to 1,725,000 cases. The rural chapter has a home service committee, and in the chairman of that committee is vested authority for local services. Mr. Goldthorpe explains:

> In a chapter in Kansas he might be the manager of the local cream station, in Iowa perhaps a county judge, in Colorado a clergyman, in North Dakota a rural mail carrier, in Illinois a young veteran starting out in business. His job is to see that the chapter has home service workers spotted about the county to serve the people who need Red Cross assistance. Unlike their city cousins, rural home service workers must often travel many miles in order to carry out their missions.

Activities of Volunteers. The total number of volunteer workers on all types of services numbered almost 200,000 in the rural chapters in the year ending in June, 1946, and they gave a total of more than 13,000,000 hours in activities. In the production corps, over a million garments and over 7,500,000 surgical dressings were produced by more than 160,000 volunteers. There were some 8,400 volunteer nurses' aides in rural chapters. The staff assistance corps numbered more than 3,700 persons. In the 1946 drive for funds, the rural chapters responded by contributing $18,000,000, which was 116 per cent of the goal assigned to them.

Types of Rural Services. The rural nutrition program is carried on largely in cooperation with the agricultural extension service, a federal-state-local program, in most counties. It is carried on mainly by traveling nutritionists who arrange exhibits and demonstrations and disseminate information. By means of institutes of the Junior Red Cross, teachers in local schools are being provided with material concerning the nutrition service. At some colleges of agriculture, the students of home economics are trained to become qualified nutrition instructors in the communities in which they will live after they leave college.

The Red Cross program of water safety is aimed to reach every person in America who wants to learn swimming and life saving. There is special emphasis through community learn-to-swim campaigns. In the 1930's a Census Bureau report indicated that 60 per cent of the nation's drownings occurred in places with less than 2,500 population.

Accident prevention programs are offered to rural as well as to urban communities. There is a home and farm accident prevention course which is specifically designed for rural residents. Training in emergency care of victims of accidents is of special value in rural communities because medical aid is usually not readily available. This is particularly the case in the winter months. According to the National Safety Council's estimates, 16,000 residents on farms are accidentally killed annually, and 1,500,000 are injured annually. These figures argue for widespread knowledge of first aid in rural areas. Courses in first aid are available through the chapters. In rural areas, instruction is frequently arranged through farm organizations, churches, schools, and young people's groups. "Standard" and "advanced" courses are offered to adults. A junior first-aid course is conducted for those aged 12 to 15 years.

Highway first aid is of signal importance in the rural communities. About 2,000 highway first-aid stations are strategically located at local gasoline service stations, fire houses, tourist homes, inns, and at other places, for the purpose of providing aid to the motoring public. They are manned by trained volunteers and have first-aid equipment. More than 10,000 mobile units have been organized and are operated by trained persons, including truckers, policemen, and instructors. The whole system is arranged to give emergency care along highways until medical aid can be secured.

Nursing. We already have noted the pioneering work done by the Red Cross in providing public health nurses in rural areas. The official Red Cross policy has been to withdraw from the field as the local health units and other public agencies are able to employ more nurses. Thus the Red Cross has pointed with pride to declining statistics in its annual reports. In 1945, the report stated that in 1922 there were 1,036 chapters that maintained public health nursing, but that the number had declined to 181. However, a reiterated statement of policy to withdraw from the field has drawn considerable comment. The Red Cross is being asked to reconsider and to determine its future role in consultation with public agencies responsible.

An incident described in the report [3] illustrates the situation. The

Acioto County Red Cross Chapter began public health nursing in 1921, and included public school nursing. A few years later the county employed two nurses who took over duties in two-thirds of the county, leaving the remainder to the Red Cross nurse. By 1933, the county took over the more rural areas, and the Red Cross nurse served one city and one town. By 1944, governmental and private organizations were employing 14 public health nurses in the county, and the Red Cross withdrew from the field. Between 1931 and 1944, however, the Red Cross nurse had taught 69 home nursing classes, and the county chapter decided to put its efforts into promoting this aspect of the program. Since the national program was begun, Red Cross nurses have driven their cars over the back roads of half the counties of the United States.

Instruction in home nursing is given by graduate nurses whose qualifications are certified by the Red Cross. In rural communities, the teacher may be an itinerant nurse who goes about as the chapters indicate the demand for teaching, or she may be the Red Cross public health nurse at work in a county. Home nursing is an essential peacetime program that, like other services noted above, has a particular value in areas where doctors and professional nurses are not available in sufficient numbers. Home nursing is regarded as a household art, and is not designed to make professional nurses out of homemakers or to replace professional services.

The instructor teaches "what to do and how to do it." She provides the basic knowledge and skills which most homemakers will need at some time. Emphasis is put on prenatal care, the need for periodical physical examinations, and the recognition of symptoms and the reporting of them to the physician. Public health officials encourage home nursing because they know it helps to arouse an interest in community health as a whole. After instruction in simple, basic nursing skills has been given, a further interest in related aspects develops. Thus the home nursing program encourages interest in public health regulations, medical supervision of family health, immunization, and other vital measures. In the more isolated communities, home nursing instruction goes far to supplement the services of private physicians and public health directors.

Chapter 7 · FARMERS HOME ADMINISTRATION PROGRAMS

IN THE FARMERS HOME ADMINISTRATION is lodged responsibility for certain services to the economic "lower half" of the nation's farm population—a group of primary interest to those concerned with rural social welfare. The organization has its roots in the thirties, when the Subsistence Homesteads Division, Department of the Interior, and some projects of the Federal Emergency Relief Administration were combined in 1935 under the Resettlement Administration of the Department of Agriculture. This last was renamed the Farm Security Administration and was the immediate precursor of the Farmers Home Administration, which succeeded it in 1946. The program begun in that year is more limited than that of earlier years, but it includes two functions important to low income groups: a loan service and a medical care program.

The Farmers Home Administration has state offices and numerous local offices in counties.[1] The Act of 1946 redefined and limited the credit services available under the Secretary of Agriculture for farmers who cannot get the loans they need at prevailing rates (but not more than 5 per cent) and terms in their own communities from banks or other responsible lending agencies. Of interest to large numbers of low-income farmers are the availability of production and subsistence loans of up to $3,500 per farmer for buying livestock, seed, feed, fertilizer, farm equipment, supplies, and other farm needs; for refinancing indebtedness; and for family subsistence. This type of "operating credit" (Title II) will be for periods up to five years, at 5 per cent interest. These loans are somewhat similar to those previously labeled "rehabilitation" under the Farm Security Administration. Certain supervisory services will be rendered by the staff of the Farmers Home Administration when necessary. Thus professional workers advise and assist in planning and budgeting—services which lending agencies do not ordinarily perform.

Kinds of Loans. Under Title I are authorized two other types of loans which probably will be available to smaller numbers of farmers than the above. First, there are farm ownership loans, which are made up to the reasonable value of the farm and necessary improvements, to enable borrowers to buy, repair, improve, or enlarge family-type farms. Loans may not be made for the acquisition or enlargement of farms which have a value—as acquired, enlarged, or improved—in excess of the average value of efficient family-type farm units in the county where the farm is located. These mortgage loans are repayable over a period of forty years at 3½ per cent interest.

Secondly, the Farmers Home Administration is authorized to insure forty-year mortgage loans by private lenders for the same purposes as the farm ownership loans. The amount borrowed can be an amount up to 90 per cent of the reasonable value of the farm and necessary improvements. Insured loans bear an annual charge of 3½ per cent, the lender receiving interest of 2½ per cent and the government receiving 1 per cent for insurance and administrative expenses. Committees of three local citizens determine the eligibility of farmers for help. Two of the three members must be farmers.

Veterans who served in the armed forces in any war have preference for mortgage loans. Disabled veterans are eligible to buy, repair, or improve farms adapted to their capacities, provided their farm income plus their pensions will be large enough to pay living and operating expenses and to retire the debt. A special condition under which all loans are made requires that if at any time it appears to the Secretary of Agriculture that the borrower may be able to secure a similar loan from a cooperative or private credit source, under terms prevailing in the area and at an interest rate not exceeding 5 per cent, he must apply for such a loan and, if granted, accept it and pay off his debt to the Farmers Home Administration. Camps for migrant labor and the established resettlement communities are to be liquidated. No loans may be made to cooperatives or to borrowers for joining cooperatives.

Medical Care Program. During the war years over 600,000 persons in 114,000 farm families participated, through associations in more

than a thousand counties, in the medical care program. In their efforts to promote rehabilitation of farm families, the local supervisors of the Farm Security offices found that many of the farmers who came for help were in difficulty for the simple reason that they were too ill to do a good day's work. Frequently, farmers had suffered for years from hookworm, malaria, or pellagra and could not afford to pay for medical treatment. In other instances, farmers had used all their capital or had gone heavily into debt in order to pay for hospital bills for members of their families. It was soon evident that one of the most important steps toward rehabilitation for these families would be to provide good medical care at rates which people could pay.

In cooperation with state and local medical societies, the Farm Security staff worked out a special medical care program for those persons who had borrowed money from the government. Details have varied slightly from county to county, but, in general, the plan has been a very simple one. The eligible persons within the county organized a health association, with the aid and advice of local physicians. Every family agreed to pay a fixed sum, usually around $24 a year, for medical care. These payments were turned over to a trustee, who divided all the money into twelve equal parts, one for each month of the year. Then if a member of the family became ill, he might go for treatment to any doctor in the county who was taking part in the plan.

The doctors turned in their bills to the trustee at the end of every month. If the sum of money set aside for that month was large enough, all the bills were paid in full. If there was a balance, it was carried over to the next month. If the amount of money available was not large enough to pay all the bills in full, they were reduced proportionately, and each physician was paid his share. After the plan had been in operation a few years, physicians had received about 60 per cent of the face amount of their bills, and some doctors said that that was a higher percentage than they received from ordinary practice, and a much higher proportion than they had received previously from low-income farm families.

Experimental Farm Health Program. In November, 1941, the Inter-Bureau Committee on Post-War Programs of the Department of

Agriculture called upon the Farm Security Administration, because of its experience in setting up prepayment plans among farm families, to help develop rural health service programs for all farm families. This was to be an experiment in applying prepayment medical plans to rural areas. Many farm leaders told the department that better medical care was urgently needed. State agricultural planning committees recommended to the Secretary of Agriculture the establishment of health service programs and the extension of public health units to counties hitherto without service. The Inter-Bureau Committee on Post-War Programs then set up a method of selecting counties for an experiment and of learning about the interest of local people in a program. The result was that six associations were successfully launched between July and November, 1942. These were associations in Cass County, Texas; Hamilton County, Nebraska; Nevada County, Arkansas; Newton County, Mississippi; Walton County, Georgia; and Wheeler County, Texas. A seventh plan in Taos County, New Mexico, was set up on a similar basis as an outgrowth of an adult education project. These seven projects were included in a study made by the Bureau of Agricultural Economics, results of which were sent to a subcommittee on wartime health and education of the Senate Committee on Education and Labor.[2]

The organizations were named "tax-assisted local voluntary health associations." The number of farm families enrolled totaled 9,287, with 41,700 persons—about 50 per cent of all farm people in the seven counties. Practically all private medical practitioners, hospitals, druggists, and dentists cooperated during the first year, and then opinions began to develop pro and con. Federal funds were used on a declining scale, and at the end of the second year the total cost of medical care per family was $48.17, and the government paid $28.79 of this amount.

There experiments demonstrated certain elements of strength and weakness in tax-assisted voluntary health associations. None could have started without federal assistance, nor could they be expected to continue without it. For one thing, the membership was heavily weighted with low-income families. The member families spent about $50 a year per family for medical and dental care, whereas throughout the entire United States the expenditure per family for

medical care alone was about $100 per family in 1942. The associations were not spending enough to secure complete, high-grade medical care. The county unit was described as wholly inadequate. "It is clear that the problem of rural health is inextricably bound up with the entire health problem of the nation and cannot be solved without drawing upon the total resources of the United States—rural and urban," the Bureau of Agricultural Economics reported to Congress in 1946. The experimental program was discontinued in 1946, but the record of experience is expected to be valuable in the making of future plans.

Chapter 8 · RECREATION SERVICES

RURAL YOUTH has demanded, with growing insistence, adequate recreation facilities. At many times and places there are informal recreation activities in rural communities. These are provided in homes, and in connection with fraternal orders, school events, church socials, and the various social organizations of neighborhoods and communities. Baseball is important in rural community life. Often the high schools have become committed to developing recreation. These demands were multiplied many times by the experiences of World War II. The young men and women in the armed services from rural communities became familiar with U.S.O. Clubs, Red Cross recreation centers, and similar services. When the movement for "living war memorials" got under way, people in rural communities began to plan recreation centers or other facilities for leisure time activities. As one farm woman remarked, "Our boys have been writing about the U.S.O. Clubs—they will expect us to provide something like them in our own communities."

Public Opinion as a Factor. The lack of recreation facilities is frequently remarked and is itself undoubtedly one of the major social problems. "No decent place to go" is heard many times. And a major aspect of the problem is traced at once to public opinion. Rural youth is asking, for example, for opportunities for dancing, and such proposals are opposed by many churches. Indeed, a social scientist reports from his field studies that just prior to the war, rural church opinion was the chief block encountered by young people who tried to persuade community leaders to organize recreation services for them and others. At the 1946 Recreation Congress of the National Recreation Association, Mrs. L. W. Hughes of the National Congress of Parents and Teachers, summarizing a discussion on recreation in rural areas, reported that rural people generally recognized that there was more leisure time than ever before, and as a consequence there was a corresponding concern with the way in which it would be spent.[1]

Agencies Responsible. Rural recreation services are the responsibility of the many agencies of the community. A number of agencies offering youth services already have assumed many responsibilities, and their programs are considered in Chapter 9. The emphasis in the present chapter will be on the methods of organization whereby the social and economic resources of communities may be brought to contribute to the provision of systematic services, and on illustrations of the way communities have demonstrated tested methods.

At the 1946 Recreation Congress there was unanimous agreement in the section on recreation in rural areas that "all the organized resources of the community needed to cooperate in providing the right kind of opportunities and service—homes, churches, schools, parent-teacher associations, clubs, newspapers, and many other agencies. The value of this cooperation lies in the development of public understanding of what a good, well-balanced recreation program can do for a community." The great need is for leadership with both the training and the motivation to carry through a plan. Clearly such leadership must and will come largely from the rural community. "The same people who made and raised the money to finance the war, who sold the war bonds, carried on paper, metal and fat-saving campaigns, can with proper direction and suggestion put on a recreation program."

Types of Recreation. When the group at the Recreation Congress came to consider the matter more specifically, a number of illustrations were given. Recreation in the home was considered basic for family solidarity, and it naturally varied with families and their interests. Conversation was recommended as a recreation. Other suggestions were cultivation of hobbies, study of the stars, the trees, the birds, the flowers, and "all the setting so lavishly provided by nature." Camping was cited as "one of the best projects to draw a family together in a recreation experience." One community arranged during the winter months for an institute to train the young people toward directing their recreation program the following spring. Much attention was given to the veterans. One veteran, only a few weeks in civilian life, "pleaded for more groups of older young people which he might enter for companionship and service." It

was remarked that many veterans' standards of recreation had been influenced by the well-attended U.S.O. clubs.

Activity in Towns. The National Recreation Association recently summed up its experience in providing systematic recreation facilities in the small community.[2] Often, the report points out, the small community approaches the matter in a negative way. "We can't have such-and-such a program or so-and-so activities here. We're too small. We can't afford it. We don't know how to start." But the message of the national organization is this: "You can have community recreation—no matter how small your town is." In its booklet, *The Town Takes a Job; Recreation for the Small Community,* the Association has assembled illustrations which provide "a record of the job done by other communities." These illustrations were taken from fourteen communities in as many states, the towns ranging in population from 1,000 to 8,000.

Tested Methods of Organizing Public Recreation. "One person who really believes that the town needs recreation can convince many others that he is right," it is stated in the publication. The persons thus convinced can become a recreation committee. This committee must be a working group, able to meet frequently to plan its work and gather information for its own guidance. Ways of getting information include talks by recreation leaders in nearby communities and counsel from state departments that may have recreation specialists whose duty it is to visit small communities. In the state of Minnesota, for example, advice is available from the State Department of Education and the extension division of the State University.

The National Recreation Association invites inquiries directly from interested citizens: it asks people to tell what they have been doing and to ask in specific terms for the necessary aid. The Association advises a local recreation committee to divide into subcommittees which will learn what opportunities the town has, consider how a community recreation program could supplement existing organizations, try to evaluate desirable and undesirable features of available recreation facilities, and finally plan the kind of program the particular community needs. The plan will be influenced by what is

already available, what the recreation committee feels is needed, what the community feels it should spend, how the bill will be paid, and who will be available for directing the program.

The National Recreation Association recommends in general:

A year round program for all age groups supported through public taxation, conducted by trained leaders;
A suitable building that may be used as a meeting place for community groups;
Public playgrounds for children;
Public play areas where boys and girls may play such games as baseball and softball and volley ball.

But many communities decide they cannot have all of these at once. Then, the booklet goes on, "You may have to start with a baseball diamond—and work toward summer playgrounds." Or start with "summer playgrounds—and work toward a year-round program." Or "start with volunteer leadership—and work toward paid leaders." Or start with "private contributions—and work toward public tax support. . . . The important thing is to start and to start with something you think you can accomplish." Then too, the recreation committee will have to be aware of public relations. It will have to conduct publicity, call a mass meeting of citizens, meet with boards of directors of many organizations, and use other means of keeping the community in touch with the program.

One peculiarly valuable service of the Association to rural communities is provision for direction of institutes for training recreation leaders. Staff service is available to conduct institutes where training is sufficiently thorough to provide local community leaders with stimulus, demonstration, and knowledge that will enable them to conduct a wide range of activities. In 1946, 9,700 persons, most of them volunteers, attended 54 training institutes in rural areas in 15 states, all conducted by staff members of the National Recreation Association.

A Look at the Record. The following five illustrations are from *The Town Takes a Job.* They are given in the brief summary form in which they were presented. The population figure following the name of the state refers to the town chosen for illustration.

PENNSYLVANIA (POP. 1,053)

Citizens
- Held a public meeting to discuss the need for a recreation center
- Investigated available building sites and property
- Considered how to raise funds
- Incorporated a recreation center
- Elected a board of directors
- Held a street fair to start a building fund for the future center
- Planned a summer playground to start at once
- Engaged a trained playground worker as director for the summer program
- Carried out their summer plans and expanded them annually
- Started occasional recreation activities during the winter and expanded them the following year into a regular winter program conducted in a borrowed building
- Purchased a building and financed it by
  - Street fairs
  - Building fund drive
  - White elephant sale
- Carried out a full year-round recreation program using paid workers and volunteers.

WISCONSIN (POP. 1,500)

Discussed the need for recreation and appointed a committee which
- Organized a recreation study course of six lessons
- Planned and carried out a promotion campaign to reach every citizen using
  - Newspapers
  - Speakers
  - Letters
  - Pamphlets
- Made a survey of the community's recreation needs
- Drew up a petition for a recreation program
- Called a public meeting to discuss the proposed plans and endorse the petition to be presented to the Village Board and School Board
- Presented the petition
- Got a year-round program financed by public funds for the community.

VERMONT (POP. 2,194)

The village had a community center but needed summer playgrounds.
The leaders of the community center used the center's newssheet to
Point out recreation facilities available
Explain the need for playgrounds and playground leaders
Announce a village meeting when citizens could vote on an appropriation to be used for playgrounds
Urge all citizens to attend the meeting and vote for the appropriation
Offer the center's superintendent as playground administrator during the summer.

MINNESOTA (POP. 3,920)

A special village election passed an ordinance allowing the School Board and the Village Council jointly to sponsor recreation programs.
The next year a cooperative summer program was planned:
The School Board
Hired and paid the salaries of a director and two assistants for a summer playground program
Allowed the use of school grounds and equipment.
The Village Council
Equipped and maintained bathing beach facilities and paid the salaries of lifeguards
Provided weekly band concerts.
The Red Cross
Paid the expenses at a ten-day aquatic school for a lifeguard
Furnished the ropes for marking off safe swimming areas.
The American Legion
Sponsored and equipped a baseball team
Installed playground apparatus and maintained picnic grounds.

CALIFORNIA (POP. 3,738)

There were no recreation facilities of any kind, so made plans resulting in:
A recreation commission
A budget for recreation of $6,597 to be paid from public funds.
The Board of Education and the City Council were represented on the Recreation Commission.
The Board of Education allowed the use of schoolhouses and schoolgrounds for community recreation
After school hours

Under competent leadership.
[The Board] hired the director and assistant director and paid their salaries.
The Recreation Commission paid the bills for activities, supplies and equipment.
The City Council maintained the facilities.

Activities for a Public Recreation Program. The same booklet contains the following lists under suggested activities for a public recreation program in small communities:

On the Playgrounds	*In the Community Center*	*For the Teen-Agers*
Apparatus play	Arts and crafts	Dancing
Arts and crafts	Dancing	Games
Athletic badge tests	Games	Community service projects
Sports	Dramatics	Dramatics
Clubs	Music	Radio workshop
Drama	Clubs	Hobby groups
Games	Reading	Study groups
Music	Storytelling	Music
Nature activities and day camping	Community nights	Parties and entertainments
Parties	Parties	Nature and outing activities
Storytelling	Holiday celebrations	Sports and athletics
Special occasion celebrations	Sports	
Exhibits		
Contests		

Farm Groups. The agricultural extension service is administered by the state colleges of agriculture. A number of specialists on the state staff are assigned responsibility for working with county and township groups. State staff workers supply program suggestions periodically to local leaders. They conduct institutes; assist local leaders in conducting important events, such as festivals and pageants; and offer a counseling service to farm people. These latter years they have given a great deal of attention to advising with respect to programs among "older rural youth," aged 18 to 24.

In a discussion of the development of recreational resources and activities conducted among farm people in Iowa recently, the fol-

lowing aspects were mentioned. On the one hand, it was stated, farm people are becoming more interested in sports and festivals. Youth leaders increasingly are furnishing leadership in recreation; it is easier than ever to go to recreation events; rural communities are beginning to employ leadership for activities in community halls, athletic fields, and swimming pools; and high schools sponsor many community events. Others stated, however, that the growing commercialization of recreation has tended to lower social standards; that it was hard to overcome the habit of being a spectator at games; that small neighborhood parties are not so common as in an earlier age; and that during the war the heavy demands for hard farm work had interfered with leisure-time activities.

Published Guides. Numerous guides suitable for use by volunteer leaders have been compiled. Two will be cited here. The Children's Bureau published in 1936 a *Handbook for Recreation Leaders*, compiled by the late Ella Gardner. It was reprinted in 1945 because of its usefulness.[3] Miss Gardner served as a specialist in recreation on the staff of the Children's Bureau and later in the Extension Service of the United States Department of Agriculture. The handbook is based on Miss Gardner's experience with recreation programs in rural areas. Numerous suggestions are made as to the uses to which the material may be put in homes, clubs, community groups. Carefully prepared indexes are designed to assist even the inexperienced in the building of recreation programs; and a section lists various types of "mixers," games, dramatic numbers, and musical activities. In addition, there are clear "suggestions for the recreation leader," including both general rules and specific directions on how to plan a community party, recreation for a small group, a picnic, and other social activities.

The National Recreation Association reprinted in 1946 a manual, *Rural Recreation*, first published in 1921, with somewhat similar purpose.[4] The latest edition includes contributions, based on her experiences, by Jane Farwell, who has been training leaders for recreation activities in rural communities. This book, after asking rural people to look around for only a few minutes to see the opportunities for recreation, then tells how to organize and carry on

specific activities in the form of home play, school play, picnics, social recreation, stunts, community dramatics, music, and camping. Included are "active team games" and "not so active team games." There is a "chart of seasonal activities."

Parks. In 1940, 52 counties reported a total of 197,350 acres in county parks. County park facilities were both erected and improved in many instances through the Work Projects Administration, which functioned between 1935 and 1943. Through W.P.A. an average of ten public buildings per county were erected or improved, and large numbers of local athletic fields and playgrounds were provided. Among the well-known recreation areas are those maintained by the national and state parks and forests. The National Park Service provides numerous facilities for picnicking, camping, swimming, and winter sports.

Cooperatives and Recreation. Cooperatives for purchasing and marketing are much more numerous in rural than in urban communities. A number of the state and regional associations now encourage the organization of recreation "as closely as possible with other cooperative activities." For example, the Ohio Farm Bureau Cooperative Association stimulates wide recreation and informal educational activities among young people and adults. The Cooperative League in the U.S.A. has a recreation specialist on its staff for counseling and for the training of leaders. There is a Cooperative Recreation Service, which has published manuals, folk games, and song sheets.

Chapter 9 · YOUTH SERVICES

SERVING COUNTRY YOUTH was the central theme of an inquiry made by H. Paul Douglass in the early 1920s. Dr. Douglass considered the programs offered by a group of voluntary agencies serving youth in rural communities. Dr. Douglass' book, *How Shall Country Youth Be Served?* was published in 1925 and recorded that within the territory covered the rural youth were only partly served, and that the services generally tended to center in villages and towns and did not reach the large proportion of the open-country young people.[1] In the twenty years intervening, there undoubtedly has been more extensive organization, and a few new organizations have appeared. But rough estimates indicate that only about 25 per cent of the village and farm youth participate in all types of organization. It is worth noting, too, that in most years about half of the rural youth go to cities to live and work. Those serving rural youth are therefore serving two distinct groups, not always clearly defined: those destined for city life and those destined for rural life. This dual objective intensifies the problems of the rural youth-serving agencies.

Boy Scouts of America. The organization of the Boy Scouts of America includes 540 local councils and approximately 3,500 organized districts, with 2,200 scout executives. These councils have districts with extensive rural areas and population. For example, the Red River Valley Council has an area one-half the size of the state of New York, with one-thirtieth of New York's population. It includes 167 towns, seventy-seven of which recently reported that scouting had been organized, but all towns of over 1,500 population already had scouting. In 1946, there were 15,983 rural scouting units, with a membership of about 300,000, in 13,000 communities. Some training in agriculture is available to many scouts. Generally the boys in a town join a pack or troop in a town. Then, in nearby neighborhoods, the boys may have a den or patrol. Boys in isolated communities, or those who live where no unit is available, may participate in the program as "lone scouts." [2]

There is "cub scouting" at age nine, boy scouting at age twelve,

and senior scouting at age fifteen. Professional leadership is furnished from the 540 local councils. The Red River Valley Council [3] has a professional staff of seven persons. Scouting units frequently are sponsored by churches, schools, clubs, or farmers' organizations. The neighborhood patrol is particularly adapted for such sponsorship under a local committee. Scout training involves instruction in many practical skills; it also includes emphasis on citizenship, physical fitness, and character development. In the constitution, the purposes of the organization are defined as "promoting, through organization and cooperation with other agencies, the ability of boys to do things for themselves and others, to train them in scoutcraft, and to teach them patriotism, courage, self-reliance, and kindred virtues. . . ." The Scout oath provides a code of conduct.

Girl Scouts of America. Scouting for girls is organized under almost 10,000 local leaders in rural communities. There are more than 100,000 rural members from seven to eighteen years of age. During recent years, projects in gardening, canning, and nutrition have been emphasized. The development of good citizenship, well-rounded personalities, and participation in community affairs have been among the aims everywhere. Girl scouting is said to be an organization "in which to learn and practice democracy." The Girl Scout Promise and Laws offer a code of conduct.

A girl may become a brownie scout at age seven, a girl scout at age ten, and a senior scout at high school age. Local groups are planned "for a moderately sized group of girls." It is generally recommended that a brownie troop be limited to sixteen girls and a scout or senior troop to thirty girls. Eight is the minimum number required for registration. Troops usually meet once a week. In each community the direct responsibility is placed on an adult troop committee. Local organizations frequently sponsor girl scout troops. There are numerous country school troops. Professional leadership is provided to rural communities by regional executives, and individuals may correspond with the Lone Troop Advisory Service at national headquarters.[4]

Camp Fire Girls. The Camp Fire Girls offers a program to girls between the ages of ten and eighteen, with a junior organization for

those eight and nine years of age. Ordinarily, from six to twenty girls meet under the leadership of an adult volunteer, called a guardian. The group may be among girls in a church or a school or a neighborhood. The group may have one or more sponsors, or a sponsoring committee from among the members of a community organization. The purpose is to provide an opportunity for personal development through group experience. These group experiences are such as to develop skills, to practice democratic methods and mutual aid, to provide leisure-time activities, and to aid the members in enriching everyday life. The local programs are flexible and may be modified by resourceful leaders.

Camp Fire Girls does not have full statistics on the number of members in rural communities. Its officers state that at least 25,000 members live outside the jurisdiction of any local council, on farms and in places of less than 2,500 population. Many of the local councils which have headquarters in cities are actually area councils. An example is the one at Des Moines, Iowa, which serves small communities within a radius of 100 miles of the city and has a substantial part of its membership in these towns.[5]

Young Men's Christian Associations. The Young Men's Christian Associations have been organized frequently in county units, and also through cooperation between city associations and nearby counties. Y.M.C.A. group activities among boys and young men, including Hi-Y clubs for high school boys, emphasize organized play, study of religious issues, discussions, community service, and agricultural projects. Vocational guidance also is stressed. "Growth into fulness of Christian character" is an aim of all associations. Local professional leadership is furnished by secretaries who do county work and by those units which combine counties or cities and counties. Local activities are the direct responsibility of volunteer leaders.[6]

Many state secretaries furnish supervision and promote extension of the activities. The county association is an organization of citizens which raises the budget and employs the secretary. The county association then organizes local committees in communities and enlists the necessary leadership of a group of boys or young men, who

plan and direct the local program. Much of the work of the associations goes on in cooperation with other organizations, including churches and schools. Summer camping has been encouraged by the Y.M.C.A. Special plans have been worked out to bring farm boys to camps. There were, in 1945, 91 town and country associations, with 8,691 members and 79 paid secretaries.

Young Women's Christian Associations. Through county and district units, girls and young women participate in the method of association promoted by the Young Women's Christian Associations. Girls and women are encouraged to share their interests and experiences in order to develop their capacities and understanding and to take part in the building of a better social order. Through various activities, such as club programs, conferences, and camps, and by meeting persons of other races and nationalities, rural girls are offered opportunities for the growth of personality.

Local groups are under the direction of volunteer adult leaders. Provision also is made for local groups in territories not under professional supervision to affiliate as registered Y.W.C.A.'s and to receive program materials directly from the National Board of the Young Women's Christian Associations. The Girl Reserve Club plan has been widely extended. In the National Board of the Y.W.C.A.'s, there is a rural community division which has an agricultural subcommittee. There is also a National Agricultural Council which helps to discover and foster the interests of farm women who are members.[7]

The total town and country membership includes 99,807 women and girls living in 1,554 village and open-country communities. There are thirty-one rural administrative units under professional leadership. The smallest is one county; the largest includes the town and country population of two entire states. At least two-thirds of the members are under eighteen years of age. Of the members, 43 per cent live on farms and 57 per cent in villages and towns. About one-fifth of all the local units are called "registered Y.W.C.A.'s—they are scattered, single organizations.

Agricultural Extension Programs. One of the activities found in most counties and in Alaska, Hawaii, and Puerto Rico is 4-H Club

work, which is a part of the national system of cooperative extension work in agriculture and homemaking in which the United States Department of Agriculture, the state agricultural colleges, and the county governments participate. More than 10,000,000 young farm people have been members of these clubs. In 1945, there were 1,639,000 members. The 4-H clubs carry on a program under four aspects—head, heart, hand, health. The symbol is a four-leaf clover with an H on each leaf. The clubs are organized groups of young people who are engaged in farming, homemaking, or community activities under the guidance of paid cooperative extension workers and local volunteer leaders trained by the paid workers. Any boy or girl between the ages of ten and twenty-one years who wishes to "learn to do by doing" may enroll. The group elects its own officers, plans and conducts programs based on the needs and interests of the young people, holds regular meetings, and takes part in community activities.[8] The extension workers and local leaders aim to aid club members in analyzing their own situations, needs, and interests so that they may build programs that will help to prepare them for citizenship and to develop their physical, mental, and spiritual capacities. The professional leaders assist young people in choosing a way to earn a living, producing food and fiber, conserving resources, and improving health conditions.

In a number of states there are specially organized programs for "older rural youth," defined as work "with young people, primarily rural, out of school, and with interests between 4-H work and that of adults." These activities are generally among young people between eighteen and twenty-four years of age. Local groups of twenty to a hundred persons meet once or twice a month.

Farm Organizations.[9] The three national farm organizations have all had an interest in youth living on farms, and have furthered a number of recreational and educational activities. The Juvenile Grange was begun by the National Grange in 1888. The National Grange itself is now more than eighty years old. Chapters of the Juvenile Grange have been organized in most of the states, and more than 50,000 boys and girls between five and fourteen are affiliated. Sons and daughters of Grange members are eligible for member-

ship in the local adult organizations on the basis of full equality with their parents. In the beginning, the age of admission was set at eighteen years; later it was made sixteen, and now it is fourteen. Recent reports indicate that approximately 300,000 rural young people between the ages of fourteen and thirty years are reached by the Grange. The Grange is a farmers' fraternity. Each local has a lecturer and a chaplain, as well as other officers. The Grange has an interest in the improvement of rural schools and churches, as well as in economic and legislative matters. Most Granges feature plays and discussions, and many have sponsored baseball and basketball leagues. There is a Youth Advisory Committee of the National Grange. The Grange has supported 4-H Club work and the teaching of vocational agriculture in high schools.

The Farmers Educational and Cooperative Union admits families as members. Boys and girls from eight years up may carry their own membership cards and may take part in recreation and attend camps and classes. On attaining age sixteen, they are taken into full membership of the Union and participate in its educational and cooperative and legislative activities. The Farmers Union has called itself a school in cooperation, and it has especially urged young people to secure an understanding of the economic forces which influence the lives of all rural people. It is the purpose of the Union to offer young people full partnership in all the affairs of the organization. No separate youth locals are organized. At summer camps, training for recreational leadership in the community is stressed. There are two special projects, that of the minutemen and that of the writers. Through their work as minutemen, young people learn to speak in public. Others can receive training as participants in the writers' project.

The American Farm Bureau Federation has supported 4-H Club work and the vocational agriculture program in high schools. The Farm Bureau admits families as members. In a majority of the states, the bureau has made no attempt to set up any youth organization. In those states where the Junior Farm Bureau is organized, its activities are among the older rural youth. It has been found that in many communities young people between the ages of twenty and thirty are not included in any organized activity. The general emphasis

of the program of the Junior Farm Bureau is reported to be similar to that in the older rural youth groups in connection with the agricultural extension service. One of the chief purposes of the Junior Farm Bureau is to train young people so that they may later participate fully in the adult program. The Farm Bureau has organized numerous educational trips and has offered scholarships to young people.

Future Farmers of America. The Future Farmers of America [10] is a national organization the members of which are boys studying agriculture in the nation's high schools. The local unit is a chapter, and the teacher is the chapter adviser. The national organization aims to promote, through rural leadership, the improvement of country life and agriculture. It encourages the development of character, sportsmanship, cooperation, thrift, recreation, and citizenship. Members learn to do by doing, and undertake such activities as public speaking, buying and selling cooperatively, and financing of farm projects. There are more than 7,500 local chapters under the leadership of as many teachers of vocational agriculture. The total membership is over 300,000.

Rural Youth of the U.S.A. Rural Youth of the U.S.A.,[11] an independent agency which is a continuation of the Youth Section, American Country Life Association, has a method whereby youth groups in school and out may affiliate and consider rural matters of mutual interest through conferences and publications. Discussions among rural youth recently held indicate that some of the issues being considered are: Should youth have its own meeting place; can available facilities be used; is play enough; should there be any activity which has schooling connected with it; what is the nature of a vital program and can we have one; what is the school's job; what is the churches' part; and can townspeople and farmers pull together?

Youth in Churches. About half the people of the nation—and thus probably about half of the children and young people—are affiliated with churches. But a recent extensive study of rural churches in Iowa revealed that less than half of them had any organized pro-

gram for young people, outside of the church or Sunday school.[12] The programs of youth groups in rural churches tend to be much the same as youth programs elsewhere. They are programs in the country, but they are not rural programs.

The specifically rural youth movement of the Roman Catholic Church is the comparatively new one called the Catholic Action Farmers.[13] A group of six or eight young people in a parish meet as a unit about once a month. The aims are to help rural youth to appreciate farm life and its opportunities for living a full life; to apply Christian teachings to farm life; and to foster and strengthen "the three basic units of Christian rural living"—the farm family, the farm community, and the parish.

Employment Services for Young People. When the public employment service, which had operated on a national basis during the war, was returned in 1946 to a federal-state system, the United States Employment Service [14] formulated certain basic standards and required each cooperating state to agree that it will adhere to the policies and procedures. A regulation issued by the United States Employment Service indicates that the agency regards as important certain special safeguards for youth and that it encourages cooperative relations with schools and other community agencies. It is the policy of the Employment Service, among others:

To refer young workers to jobs which are not injurious to their health and welfare, and which insofar as practicable offer opportunity for advancement. . . .

To facilitate employment of youth entering the labor market by promoting employer acceptance on the basis of qualifications. . . .

To maintain cooperative relations with the schools, training agencies, and other community groups to facilitate the entry of young workers into employment. . . .

To provide employment counseling service to any applicant of employable age who requires and wishes such assistance in becoming vocationally adjusted.

Chapter 10 · CONTROL OF CHILD LABOR

"EDUCATION in this county is in competition with beans, and beans are winning out," it was once said at a Congressional hearing. Many children labor in the fields. Few states have laws that protect children in agricultural work. Federal child labor laws are so limited that they provide little protection for those in agriculture. Part of the problem has arisen with the development of large-scale agriculture. Children of migrant farm laborers have been employed in agriculture ever since industrialized agriculture took to mass production of specialized crops that require hand labor. Much of the work these children do is as difficult as factory work, which children are prohibited from performing. This is all aside from the child on the home family-type farm, where parents direct his work, and where he usually goes to school and works after school and during vacations.

The number of migrating farm workers and their children is not known accurately. Some estimates place the total number of workers at from 600,000 to 1,000,000. Usually members of families accompany the workers. "Hundreds of thousands of children—some as young as six—follow the crops with their families and work in the fields to help produce the food we eat," wrote Ione L. Clinton of the United States Children's Bureau in 1946.[1] "The growers who raise this kind of crop—beans, cotton, potatoes, prunes, sugar beets —always need a great many extra workers at harvest time." In Hidalgo County, Texas, in 1941, the Children's Bureau found that three-fourths of 600 migratory children aged six through seventeen worked in the fields. More than half the eight- and nine-year-olds worked. The New York State Department of Labor interviewed 600 migrant laborers in 1945 and found that one-fourth of those working were children under fourteen years of age.

The type of work is not easy for adults, and its effects on children are unfavorable, both physically and emotionally. Berries are sometimes picked in a rain, or right after it. Heavy boxes or bags must be lifted. "They almost never get a proper lunch," writes Miss

Clinton, "and there may be no safe drinking water in the fields." They go back and forth in trucks that may be unsafe or overcrowded. The migrant children are almost sure to be living under conditions in which schooling is neglected. Migrants generally are subjected to social ostracism. Even when they go to a strange school, the community sentiment, even that of teachers, often is against their coming to school. "Consider the emotional effect on children who feel not only the insecurity and fear of their parents, but the social ostracism to which migrants are subjected wherever they go," Raymond Fuller wrote in 1940. "The children therefore live in an atmosphere both of defeatism and of inferiority feelings." In spite of hard work, these children are able to earn very little.

Two Federal Laws. Two of the federal child labor laws apply to a limited degree to agriculture. The Sugar Act of 1937 makes producers eligible for governmental benefits only if farmers do not employ children under fourteen years of age in production, cultivation, or harvesting, and do not permit those between the ages of fourteen and sixteen to work more than eight hours a day. But the regulations do not apply to children whose parents are growers owning 40 per cent or more of the crop. The Fair Labor Standards Act of 1938 sets a minimum age of sixteen for children engaged in a trade or industry sending goods into interstate commerce. But the provisions do not regulate farm work outside of hours when children are required to be in school. Since the enforcement of school attendance laws varies widely, large numbers of children working on farms are not protected by this law. The child labor provisions are administered by the Department of Labor.

State Laws. Child labor laws setting a minimum age for work on farms during school hours and after school hours are in effect only in North Carolina, New York, New Jersey, California, the District of Columbia, Hawaii, and Puerto Rico. In New Jersey, work in connection with the home farm and directly for the parent is exempted, and in North Carolina there is an exception for work under the direction or authority of the parents. The states of Ohio, Pennsylvania, Massachusetts, and Florida have set a minimum age for agricultural work

only during school hours. Eighteen states have general prohibitions which may be applied to work during school hours. But twenty-two states and Alaska have established no standards at all for farm work by children.

Recommendation of Rural Standards. The National Child Labor Committee, which has worked at this problem since 1904, developing standards and suggesting remedial legislation, recommends the following standards for the employment of children in agriculture: [2]

SCHOOL ATTENDANCE

No child should be employed during the hours when compulsory attendance laws require his attendance at school. School attendance should be compulsory for the entire term for a child under 16 years, and the school term should be not less than 9 months.

MINIMUM AGE

No child under 14 years should be employed at any time in industrialized agriculture. (Industrialized agriculture does not include work on the home farm, or on neighboring farms employing a small number of workers.)

HOURS OF WORK

No child under 16 years should be employed away from the home farm for more than 8 hours in a single day. Hours of employment on a school day should not exceed 3.

WORK PERMITS

Special agricultural permits should be required under 18 years for employment in industrialized agriculture, based on proof of age and evidence of physical fitness.

WORKMEN'S COMPENSATION

Minors employed in industrialized agriculture should be included in workmen's compensation laws.

The Migrant Workers. As for migrants, the problem is declared by the Committee to be basically federal, because migrants are always moving across state lines.[3] The following measures are among those suggested:

Federal Action

It is of little use to require school attendance of migrant children in one State if, because this curtails their employment, the families merely go to a different State for employment.

Inclusion of agricultural child labor under the Federal [Fair Labor Standards] Act would establish a 16-year minimum for employment *during the hours the public schools are in session;* it would permit work outside of school hours at 14 years, subject to regulation by the Federal Children's Bureau. (Under the present Act children in agriculture are covered only when they are legally required to "attend" school. This means that where the State compulsory attendance law is not interpreted to apply to migrant children, or where children in rural districts are not required to attend for the full term, the Federal law does not apply.)

State Action

Amendment of State school attendance laws to require regular school attendance up to 16 years without exemption for children working in agriculture, and corresponding amendment to State child labor laws to prohibit employment of children under 16 years in agriculture *during school hours.*

Local Action

Organization of citizens committees in local communities to secure a better understanding of migrants and an acceptance of the migrant families in the activities (including the schools, youth groups, etc.) of the community.

Cooperation of health and school personnel in planning for health examinations of migrant children, prior to admission to school, as a method of allaying fears of parents of resident children.

Cooperation of public or private groups in seeing that suitable clothing, etc., is supplied where this lack keeps children out of school.

The situation we are considering is interrelated with many others. Child labor is recognized as one of the chief causes of absence from school in many states. Yet this form of child labor is so closely related to the economic situation that legislation alone cannot change it. Low-income families, poor schools, indifferent enforcement of attendance laws, inadequate child labor laws, these are all aspects of the total situation. It will be difficult to make progress with more adequate child labor laws until there are better economic conditions, longer school terms, and enforcement of attendance laws.

Chapter 11 · SOCIAL SERVICES UNDER CHURCH AUSPICES

ALTHOUGH APPROXIMATELY 70 PER CENT of the local churches in the United States are in communities with less than 2,500 population, they have only about one-third of the total church membership.[1] Thus there are numerous small churches, and these parishes or congregations do not administer social welfare programs under professional direction. The clergyman is a citizen who is frequently interested in organized services, and whose cooperation is often essential if a program is to be promoted. Many of the rural churches do informal social work or carry on activities of mutual aid that are of significance in rural community life.

Anna Laura Gebhard, wife of a rural minister, has written of the way the Methodist Church of Princeton, Minnesota, has been organized for the purpose of "meeting the problems of the depleted community." [2] The town had decreased in population, but the people of the church decided to follow the words of Isaiah, "Lengthen thy cords and strengthen thy stakes." They conducted a study and made many friendly visits. The church continued to "expand its program to meet the spiritual needs of persons and of the community." Extension church schools were opened. It was found that the major need was recreation for young people. The men's club secured equipment for a wide program of informal recreation. A circle of young married women was organized and provided many friendly contacts and opportunities for discussion of common interests.

The more formal welfare services of churches have been rendered through numerous institutions, mainly for children and for older people. These are maintained by units larger than local parishes, and these institutions of synods, districts, associations, and dioceses serve both rural and urban people. Hospitals under church auspices are generally located in cities, but many of these have always served rural people as well. A recent inquiry of ten boards of home missions,

made by the Home Missions Council, revealed that these alone administer 123 community centers, 14 children's homes, and 15 hospitals, health centers, or dispensaries, in both urban and rural areas. These boards report a tendency for communities to supply part of the support of institutions, and a gradual transfer of institutions to public agencies.[3]

Complete national figures for institutions under Protestant auspices are not available. There are about 1,500 private homes for older people, of which six large Protestant denominations report 212. There are also probably well in excess of 400 Protestant homes for children. In the 115 dioceses of the Roman Catholic Church, there are 369 institutions for children, with more than 20,000 members of religious orders devoted to this work. Roman Catholic institutions for the aged and infirm recently numbered 228, with 21,235 residents.[4]

Centers for Migrant Workers. One of the largest national projects of social service under religious auspices has been that of the Committee on Migrant Work of the Home Missions Council of North America. As early as 1920, women of the churches expressed a concern about the condition of the "harvest nomads" of the nation and developed systematic services for them. The local service established is largely in the form of a day care center for children. In 1946, some thirty persons were engaged on the national staff for year-round service, and a much larger number of persons was employed for temporary service during the height of the harvest season.[5]

A community in a northern state centers around the growing and harvesting of beans. Ordinarily it has 2,000 people. But during the harvest the total population increases to 7,000 persons. There is not enough labor in the community or even nearby to harvest the crop. The growers thus call on a number of the large army of uprooted people who move from crop to crop across the land. There are throughout the United States about 600,000 of these laborers, but accompanying them on their travels for subsistence are several times that number of women and children. If these migrant workers and their families were to be gathered in one place, they probably

would make a city larger than Detroit, Philadelphia, or Los Angeles.

When the new recruits come to the community they live in tents, tourist camps, or temporary shacks made of scrap material. Often they are destitute when they arrive. Ordinarily they earn so little that there is no reserve to support them for long periods of travel. The community to which they come for a brief period of labor is itself limited in its resources. It has no means of providing adequate services for 5,000 extra people for a few weeks. Despite these inadequate services there were many people who gave thought to this situation. The mayor called a public meeting to ask people to contribute ideas. They had heard that the Home Missions Council was interested and invited a staff member of the council to the meeting. Fifty citizens came to the session and learned what other communities had done. About twelve local organizations were represented.

They decided to launch a community project. First, they learned what would be available by pooling resources. The county health department promised to send a public health nurse. Soon forty-eight organizations and those who owned the packing houses contributed financially to the project. They set up a nursery for the smaller children whose parents worked in the fields or the plants. They planned a program for the children of school age who usually had no care after school hours while their parents were still at work. The staff of workers conducted religious worship as a part of the program.

This type of project has been maintained in many states. "Cooperative missionaries" are sent by the Home Missions Council to man the centers. They are ministers, teachers, nurses, and recreation workers. One of the more important aspects is not the direct service but the professional suggestions which help people to work together. Through this program alone, contact has been established with about one-fifth of the nation's migrant agricultural workers. In conducting the program, those responsible have encountered many problems. One of these is the attitude of many of the residents of the rural communities. They themselves feel insecure and have poor resources. They live under conditions which actually create migrant workers. Sometimes the communities resent a program which they think offers services to migrant labor—for example,

a nursery school—which are not available to residents. On the other hand, the "harvest nomads" feel that they encounter discrimination, condescension, and exploitation. By patient labor, some of these difficulties can be dealt with.

Methodist Women in Town and Country. Varied services are rendered under the auspices of the Bureau of Town and Country Work, Woman's Division of Christian Service, Board of Missions, the Methodist Church. The Board employs approximately a hundred professional women for work in communities with less than 10,000 population. "Like the country doctor, the rural worker must be a general practitioner," the latest annual report of the Bureau continues. "Her work includes case work, group work, community organization, and religious education." The program is carried on in varied situations: a mining community of Vermont, the bayou country of Louisiana, a community center on the border between Mexico and California. The paid workers help to develop local, lay leadership.

These workers are trained to aid local people in understanding their communities, and to enlist the aid of other professional persons with specialized skills in social welfare when these are needed. It is as important to know what not to attempt by way of local programs as it is to know what to try to initiate. Rural professional workers who are well acquainted with available resources and who know how to assist rural people in using the resources are able to make a valuable contribution to the total community process. "Cooperation is the keynote of rural work."

Salvation Army. The Salvation Army, which has long been known for its work among the disadvantaged people of cities, is now appealing to citizens of rural communities. It has organized 2,300 Rural Service Units. The committees that administer the rural service program are set up by Salvation Army officers but are composed entirely of "non-Salvationists"—persons who are chosen because their work, or interest in people, keeps them in touch with their fellow citizens and informed of particular needs, local misfortunes, or emergencies.

Each Rural Service Unit raises its own funds, and each committee

acts autonomously, obtaining use of the nearest Salvation Army hospital or other facilities, and using funds upon its own authority and discretion to aid local families or individuals in need of financial or other aid. Through its local welfare fund, each unit enables principals, teachers, nurses, and social workers to apply for and receive many types of aid for needy families. Eye examinations and glasses, hearing aids, false teeth and other dental care, and tonsil operations and other surgical care are provided for. Fresh eggs, milk, and vegetables for rheumatic fever patients and vitamins for vitamin-deficiency cases are offered. The fund includes scholarships for local students and supports summer camps for mothers and children and hospitalization for unmarried mothers. Many other special and individual needs are considered.

National Programs Stimulating Social Services. Several national agencies stimulate and encourage the rural churches to relate themselves to rural social improvement.

The National Catholic Rural Life Conference is an organization of bishops, priests, and lay persons for the purpose of applying Roman Catholic teaching to rural life. The organization conducts an annual forum for discussion of rural issues and interests. It recommends to the various dioceses the appointment of rural-life directors, many of whom serve in this capacity part time while teaching or doing pastoral work. The Conference publishes literature and has encouraged land settlement and cooperatives. It has shown a special interest in the rural family, asking, "How can the best conditions be provided for the religious salvation of the family?" In its "Manifesto on Rural Life," it has declared that "the well-being of the nation rests to a large measure on a healthy agrarianism." The Conference has condemned large land ownerships, sharecropping and short-term leases, the one-crop systems, and the robbing of soil fertility. The Conference also conducts a large number of summer schools, where priests and laity gather for intensive consideration of economic, social, and educational aspects of rural life.[6]

The Committee on Town and Country is constituted by the Home Missions Council of North America, the Federal Council of the Churches of Christ in America, and the International Coun-

cil of Religious Education. It represents the rural interests of some forty Protestant and Eastern Orthodox bodies. For thirty-five years the Committee has encouraged the in-service training of rural ministers by means of short school sessions, usually held in the summer months for one or two weeks. One of the purposes of these schools is to increase the number of contacts of ministers with farm organizations and with movements for rural community improvement. Once a year the Committee brings together in a convocation those most concerned with the rural church and rural life, where they may plan together and educate one another. It has developed a literature and provided a center of information on rural church and community developments. It has encouraged cooperation among churches and has maintained field services, largely rendered through state councils of churches and the cooperating denominations. Through a subcommittee on land tenure, extensive studies are under way to determine the extent to which the local church can contribute to the stability of the rural community by encouraging farm ownership.[7]

Through the Committee on Sharecropper Work of the Home Missions Council, an extensive training project is being carried on for a five-year period, financed in large part by a grant from the Phelps-Stokes Fund. The Committee wishes to train young men specifically for work in the ministry in the rural South, and it also has set up numerous in-service training projects, where ministers now at work come for "community workshops" as well as formal courses. They are encouraged to undertake community projects in recreation, cooperative enterprises for economic improvement, and home improvement.[8]

The Jewish Agricultural Society—a community organization, not a religious agency—has assisted many Jewish farmers in finding homes and land. It is an outgrowth of the work of the Baron de Hirsch Fund, established to promote colonization. The Society maintains an extension service among the hundred thousand Jewish people who live on farms. It has encouraged local health and sanitary programs and aided in the development of cooperatives. It publishes practical literature and has a field staff available for local activities.[9]

Religion and Health. In 1850, in a report of the Sanitary Commission of Massachusetts, Lemuel Shattuck made an appeal first to physicians and secondly to clergymen, the *American Journal of Public Health* has recalled. Shattuck wished to have "one or more discourses annually" in general support of sanitary reform. It is a method that has occurred to many social welfare workers to this day, and it is still of value. But more important than announcements from the pulpit or annual references in sermons is systematic cooperation among minister, physician, and social welfare worker. The Commission on Religion and Health of the Federal Council of the Churches of Christ in America has encouraged such cooperation, in recognition of the community of interest among physicians and pastors. The pastor frequently has to deal with mental and emotional problems in his daily work. The clergyman, it has been recommended, should know something of the manner in which the physician works, and vice versa. Therefore, the Commission has worked closely with the National Committee for Mental Hygiene. The *American Journal of Public Health* advises health officers to "do something concrete to make medicine and the churches in their communities effective partners," and stands ready to be of assistance.[10]

The purpose of the National Mental Health Foundation is to help interpret to the public the nature of mental illness and mental deficiency, to cooperate with others in promoting mental health, and to seek higher standards of care and treatment in hospitals. It is an outgrowth of a wartime program of service to mental institutions by the several traditional "peace" churches—the American Friends Service Committee, the Brethren Service Committee, and the Mennonite Central Committee. Many conscientious objectors served as attendants in mental hospitals. Projects announced by the Foundation include gathering of reports from institutional employees as to conditions in state mental hospitals; preparation and distribution of training material for hospital personnel; and drafting of a model mental health law. The Foundation presented a series of radio dramas designed to educate the public toward understanding mental illness. One told about a well-run mental hospital, another of the therapeutic possibilities of foster home care.[11]

Illustrations of Projects: Penn-Craft Community. One of the rural projects of the American Friends Service Committee has been the Penn-Craft Community in western Pennsylvania, near Uniontown in the coal mining area. It is a community of simple homes, with fifty houses erected by miners and farmer-miners. There is a knitting mill which supplements mining, and thus the families are no longer solely dependent upon mining. There are a community center and a co-operative store. The homesteads are surrounded by gardens, ploughed land, and pasture. With each home are one or two acres. Each house cost about $2,000, and the people supplied the labor for their own structures. The total investment per home is about twice that amount, the cost of roads, public utilities, and other improvements running to about $2,000 per home. Loans have been made to families at 2 per cent interest for a period of twenty to thirty years. Many families first erected temporary structures, in which they lived while their residences were being built. The temporary buildings were then converted into poultry houses. The permanent homes are of stone, and they have all been erected with unskilled labor. Penn-Craft does not represent a back-to-the-land movement but rather an attempt to make use of the land to supplement the income from industry and cushion the shock of industrial depression.[12]

The Community Planning Council at Bricks. At Bricks, near Enfield, North Carolina, is Bricks Rural Life School, administered by the American Missionary Association Division, Board of Home Missions, Congregational Christian Churches. Once a high school and a junior college, it is now a rural-life school that has short-term events for young adults—evening lectures and various entertainments—but also a program of economic rehabilitation that includes training in farm ownership. The heart of the economic project is a credit union, owned and operated by the people themselves. They have operated the credit union as a type of "brotherhood credit" among a group of neighbors and have been able to make some loans in sufficient amounts to enable families to change from tenancy to ownership. Not a single tenant is now dependent on loan sharks.

"Everything keeps growing stronger," is the latest report, "the credit union, the cooperative store, cooperative ownership and use of a tractor . . . , farming, gardening, standards of living." Recently the community felt ready to do something effective to secure a public health nurse. Three hundred and sixty Negro families contributed from $1.00 to $5.00 a year to help pay part of the cost of maintaining a public health nurse furnished by the county health department. Through conferences, clinics, and immunization, marked improvements in health were achieved. The health council decided to become a community planning council, and is working to develop community-wide recreation.[13]

Heifers for Relief. When a relief worker for the Church of the Brethren learned of foreign communities where no milk was available, he suggested that the members of the church, many of whom are dairy farmers, contribute heifers and ship them to countries in need. They responded. Restrictions on shipping during the war prevented extensive movement of the animals while hostilities were on, although some were sent to Puerto Rico. But animals were assembled at several centers and have now gone in considerable numbers to Poland, China, and other nations. The project was particularly designed for the countries of war-torn Europe. In several instances, the animals were donated to the United Nations Relief and Rehabilitation Administration (U.N.R.R.A.), which arranged for their shipment. Roman Catholic, Friends, Evangelical and Reformed, Baptist, and other churches have had a part in the work of the Heifer Project Committee, administered by the Brethren Service Committee of the Church of the Brethren. The same church helped U.N.R.R.A. in other ways. Once a shipload of horses was being assembled, but it was not possible to employ herdsmen to make the trip. The Church of the Brethren sent telegrams to pastors, asking for volunteers. In a few days the necessary number of herdsmen appeared at the dock for the trip.[14]

Pronouncements of Rural Churchmen. The rural situation has stimulated rural churchmen of all faiths to formulate their ideals and principles and also to state specific methods by which their teachings may be translated into social action. A well-publicized declara-

tion, entitled "Man's Relation to the Land," was signed in 1945 by seventy-five Protestants, Roman Catholics, and Jews. It contained, among many others, the following statements: "Since the family is the primary institution, access to land and stewardship of land must be planned with the family unit in view. . . . A unique relationship exists between the family and the vocation of agriculture. . . . The family's welfare must therefore have the first consideration in economic and social planning."

Among the "suggested methods" of application were the following:

"Extend social security provisions, particularly health, old-age and survivors' insurance, to farm people and other rural dwellers. . . .

"Emphasize a special program of enlistment and training in secondary, liberal arts, technical and professional schools for professional service to the rural community.

"Make the family-type farm operated by the owner a major objective of legislation and planning." [15]

Chapter 12 · PROBATION SERVICES

In Most of Our States, the trial courts are authorized to suspend sentence and put the convicted person "on probation." By taking this step, the court assumes responsibility for "treatment," because if the process is well carried out the court will not impose or execute sentence. In most jurisdictions, the treatment and supervision are still carried on by the local courts, although considerable progress has been made in turning over these responsibilities to central state boards or departments. Probation practices also vary in extent from state to state. In the year 1944, for example, sentences were suspended in the cases of about two-thirds of the convicted defendants in Rhode Island and in but 12.9 per cent in Kansas; for twenty-four states reporting statistics, the percentage was 31.3.[1]

Since the purpose of probation is to restore persons to normal community life, it is obvious that the process should be carried out in connection with thorough study. Probation services at their best are started only after complete social, medical, and psychological investigations have been made. The courts should have competent persons to whom to turn for advice. Then if probation is decided upon, there is need for professionally trained probation officers who do the supervising and endeavor to make good use of community resources for the person who is given his liberty under the conditions imposed by the court.

Services Largely Undeveloped. Complete probation services are still largely undeveloped in most jurisdictions, rural and urban. Probation officers are often political appointees, and they have many more cases than can receive adequate supervision. In rural areas, the traditional method has been to have the functions carried out on a county basis, and efforts have been made to persuade each county to provide all the necessary services. The method has been marked by relatively poor results. The National Probation Association, working with many civic groups, has encouraged many state and local improvements. It has concluded, however, that under present conditions and

resources, it is too much to expect that probation services will be provided on a complete basis, county by county, throughout the United States. Thus there has been encouragement of state administration of the treatment of adult offenders through state boards of parole and probation or departments of correction.

Some State Programs. Eleven states are reported by the Association to have completely combined services of adult probation and parole, with no local offices. These are Alabama, Kentucky, Louisiana, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, Washington, and Wyoming. There are partially combined services, with local probation officers serving in seven states: Arkansas, Florida, Minnesota, Missouri, North Dakota, West Virginia, and Wisconsin. Combined services have been authorized, but the state department's probation work is as yet undeveloped, in seven additional states: Georgia, Idaho, Iowa, Maryland, Montana, Pennsylvania, and Tennessee. Thus the total number of states in which combined state administration of adult probation and parole services is authorized by law is twenty-five. Constant efforts are being made to expand state control, adopt merit systems, and employ trained social workers. In rural areas particularly, the lack of probation case work services is evident. Consultations and studies are going on in twenty states, the American Probation Association reports. In West Virginia, plans are being drawn for the development of a district detention system, with facilities available at convenient points.[2]

Local Jails. In rural areas one of the greatest handicaps in the entire system of handling offenders is the conditions in the local jails. They have been called our "worst penal institutions." The Federal Bureau of Prisons [3] inspects jails solely for the purpose of determining whether they are fit for temporarily housing federal prisoners. In 1945, 80.8 per cent of the local jails fell below a rating of 50 per cent as to administration, discipline, food, personnel, and court treatment. In 1937, only 67 per cent fell below that rating. Jails are usually maintained by counties as an adjunct of the sheriff's office. Many buildings are fire hazards. Food is inadequate. Truant girls and prostitutes are often housed together. Practically every county jail has a matron, in many instances the sheriff's wife. Her

work is usually limited to that of "turnkey" in the women's quarters. With some training, many of these persons could be of help in interviewing women offenders. But since they generally have no training, they cannot assist.

Juvenile and Domestic Relations Courts. Much more critical is the situation with respect to probation services in the juvenile and domestic relations courts in rural counties. In many jurisdictions, a considerable number of cases come to the juvenile court. Yet often the judge has no services on which to call. He literally does not know what to do with the persons before him in many instances. The result is often somewhat indiscriminate referral. It is known that judges have sent boys of five to fifteen years directly to the state reform school for the first offense. Of the juvenile court situation in rural areas it may be quite definitely stated that the courts are usually conducted by persons without special training or aptitude.

There are reported to be about three thousand areas of juvenile court jurisdiction in the United States. In some areas there is little more than legal authorization for such a court, in others the court is well staffed to carry on a program. But judges of juvenile and domestic relations courts are often also judges in other courts, and usually they have been chosen because of their qualifications for serving in the others. When judges are elected, the citizens generally do not give consideration to their qualifications to serve in a juvenile court. One-third of the state laws authorize the appointment of referees in juvenile courts to hear certain types of cases, but these are usually appointed only in the larger centers of population.

What most county juvenile courts need are: (1) access to good probation case work services, and (2) decent and adequate detention facilities. There are reports that judges are increasingly calling upon case workers in the county welfare departments for assistance in investigation of offenders or in the course of probation. Undoubtedly, court practices have been changed as county departments of public welfare have become more competent in identifying children with behavior problems and in developing skills in guidance and treatment. Such services are of special importance when no probation case work is provided by the court.

Common jails and lockups are frequently used for detention of juveniles, despite laws and despite professional opinion against such practices. Young children are temporarily detained in common jails and lockups for periods of several weeks. And boys have been put into the same cell group as adults, where they are in contact with adult offenders. In the rural counties, something is being done by detention in foster homes. But for many sixteen- or seventeen-year-olds, including the persistent runaways, there is need for a home that provides for some special measure of security in addition to a home-like atmosphere.[4]

State Programs for Juveniles. For juveniles, three states now have full state-operated court programs—Connecticut, Rhode Island, and Utah. A survey has been in process in the state of Washington, looking toward a state probation program. This is being carried on with an advisory group representing twenty-seven organizations. In the three states named, the local government unit gives way to state-administered systems, whereby full-time judges and other personnel selected for their competence operate and carry on the functions. There courts operate in districts larger than the previous local unit. At the Attorney-General's Conference on Prevention and Control of Juvenile Delinquency, it was recommended that traveling juvenile courts be provided by states so that specially prepared staffs might be available for limited periods in rural areas.[5]

Chapter 13 · VETERANS' AFFAIRS

THE HOME SERVICE ACTIVITIES of the American National Red Cross have been described in Chapter 6. The preferences granted to veterans for certain mortgage loans by the Farmers Home Administration have been referred to in Chapter 7. The rights of widows and dependents of servicemen killed in World War II have been noted in Chapter 4, "Old-Age and Survivors Insurance." There are numerous veterans' rights and benefits, and veterans are being advised by several thousand local information centers which have been functioning in rural and urban communities. Thirty-six states have established veterans' service offices. Many veterans' guides are available. The local offices of the Veterans Administration are numerous, and the services of that agency have been relatively decentralized. The purpose of the present chapter is to describe briefly certain of the "more rural" aspects of veterans' affairs and to refer only to the more general rights and benefits available to all veterans.

Training on the Farm. Approximately 200,000 veterans, some disabled, are training to become farmers under a plan combining classwork with on-the-farm training, the Veterans Administration has announced. In operation in all the states, the courses are open to veterans generally and to those with "service-connected disabilities" who qualify. Veterans participating are enrolled in a nearby agricultural or vocational school. The farm is considered an integral part of the training facilities of the school. The instructor who teaches the veteran in class must visit him on the farm regularly.[1] Under an amendment of 1947 (Public Law 377) on-farm training was recognized as a full-time educational program. To receive benefits from the Veterans Administration, the student must take at least 200 hours of classroom study a year.

Purchase of Farms by Veterans. The Servicemen's Readjustment Act of 1945 authorized loans and services to qualified veterans seeking farms. Following is a summary of the procedure whereby a qualified veteran may become a farm owner:

1. If the veteran needs advice about a locality, he may go to the veterans' advisory committee, which functions in close relationship with the county agricultural agent.

2. When the veteran has decided on the farm or equipment he wants, he goes directly to a lender—that is, a bank, another credit agency, or an individual.

3. The lender then asks the Veterans Administration to certify the veteran's eligibility for a guaranteed loan. If the Veterans Administration so certifies, an appraiser will be designated.

4. If the lender finds the appraisal satisfactory, the veteran applies to the Veterans' Loan Certifying Committee. This group reviews the application and makes a recommendation to the Veterans Administration, which in turn accepts or rejects the application.

The maximum governmental guarantee of a loan is $4,000, which may be one-half of a total loan of $8,000. Guaranteed loans on real estate are limited to twenty years, and the interest rate is four per cent. In Washington, the Veterans Administration has the final responsibility for administering this feature of the G.I. Bill of Rights.

By the summer of 1946, approximately one million veterans already had returned to farms as owners, tenants, laborers, or as members of families of farm operators. The would-be farm owner found pieces of farm land relatively high in price, and good land difficult to find. Many older farmers postponed their retirement during the war because of the shortage of labor, the need for unprecedented production, and the high prices for products. But many farmers when they retire pass their farms on to sons. Probably 50,000 farmers retire annually in normal years. Sales by absentee owners may run to another 50,000 a year. But surplus military land is being made available and reclamation projects open some new lands. Sample studies by the Information and Education Division of the War Department indicated in 1945 that about 1,000,000 veterans expressed a preference for owning a farm as a postwar occupation. But the Bureau of Agricultural Economics of the Department of Agriculture estimated that, at best, there would be only 400,000 to 450,000 farms available. Hence, it appeared that many veterans would become tenants, work as laborers under a farm manager, or seek non-farm employment. About the only possibility for homesteading is in Alaska, and there a veteran may have first choice.

Disabled Veterans. Under the present federal laws, a disabled veteran is guaranteed an opportunity to prepare for work in which he will not find himself at an economic disadvantage. But the veteran himself should note that the terms of the law are not going to be of much help to him unless he takes initiative and responsibility for discovering, and training for, the kind of work he is capable of doing. The majority of the disabled are being advised to prepare for normal work at a normal rate of pay, making the choice exactly as if they had not been injured. Persons working on farms may find more exceptions to this general advice than those in other occupations.[2]

Disabled men were being advised that success could not come without great effort and that the better their training, the more opportunity for successful jobs. Early in 1947, Dr. Donald A. Covalt of the Veterans Administration stated that 250,000 employable, handicapped veterans were jobless. There were 1,490,000 persons partially disabled in World War II, and 100,000 of them were still in hospitals. Hundreds and thousands of volunteers are needed, Dr. Covalt said, "to provide them with the family and community touch to aid in their spiritual and mental rehabilitation."

Looking for a New Job. The Veterans Employment Representative of the United States Employment Service, which has about 1,500 local offices throughout the country, may be able to assist those seeking employment. Persons looking for jobs on farms are generally referred by the United States Employment Service to the agricultural extension agent, found in most counties of the nation. The county agents have set up farmers' committees to help returning veterans find work. The county agent often knows about farms for rent or for sale. The United States Employment Service endeavors to give special services to disabled and handicapped veterans. It tries to make analyses of job specifications. If the veteran is not sure that he can carry the physical load involved in a job, a physical examination may be arranged. Veterans who are blind can also secure assistance in finding jobs through the state commission for the blind.

Summing Up Federal Provisions. Home Service, American National Red Cross, has issued a tabular summary of veterans' rights and benefits which is reproduced here in TABLE IV.

TABLE IV

GOVERNMENT BENEFITS AND SERVICES AVAILABLE FOR VETERANS

These benefits concern primarily veterans of World War II. Many are also available to others who have served since April 6, 1917. Revised October 19, 1948. Subject to change by legislation enacted after that date.

Type of Benefit	*Basis of Eligibility*	*Nature of Benefit*	*Administering Agency*
COMPENSATION FOR DISABILITY SERVICE CONNECTED	Disabilities resulting from injuries or diseases incurred in or aggravated by active service. Discharge under conditions other than dishonorable.	$13.80 to $138 a month depending on degree of disability, World Wars I and II; $11.04 to $110.40 peacetime service. Additional benefits for helplessness, blindness, loss of, or loss of use of, limb, etc.; and, if 60% or more disabled, for dependents.	Veterans Administration regional office having jurisdiction over place of residence.
PENSION FOR DISABILITY NOT SERVICE-CONNECTED	90 days' active service during World War I or II, or, if less, discharged for disability in line of duty. Discharge under conditions other than dishonorable.	$60 per month for permanent total disability. Increased to $72 after continuous receipt for 10 years, or age 65. Income limitations.	Veterans Administration regional office having jurisdiction over place of residence.
READJUSTMENT ALLOWANCE (unemployment benefits under GI bill)	In active service on or after Sept. 16, 1940, and prior to July 26, 1947, or end of an enlistment beginning between Oct. 6, 1945, and Oct. 5, 1946. Must have had 90 days' service; if less, discharge for disability incurred in line of duty. Discharge under conditions other than dishonorable.	Payment of $20 per week, less any wages received in excess of $3. 8 weeks' benefits for each month of first 90 days' service. 4 weeks per month thereafter. Maximum number of weeks 52. Self-employed veteran entitled to difference between net earnings and $100 per month.	Veterans Administration through state unemployment compensation agency.

UNEMPLOYMENT COMPENSATION—STATE	Veteran must have accrued credits prior to entering service. No service requirements.	Credits preserved and available after discharge. State laws govern use in relation to Readjustment Allowance.	State unemployment compensation agency.
LOAN GUARANTY	In active service on or after Sept. 16, 1940, and prior to July 26, 1947, or end of an enlistment beginning between Oct. 6, 1945, and Oct. 5, 1946. Must have had 90 days' service; if less, discharge for disability incurred in line of duty. Discharge under conditions other than dishonorable.	Administrator of Veterans' Affairs may guarantee up to 50 per cent of a loan for purchase or construction of homes, farms, or business property, or farm or business equipment. Maximum guarantee $4,000 on real estate; others $2,000.	Veterans Administration regional office having jurisdiction over place of residence.
FEDERAL VOCATIONAL REHABILITATION (in schools, colleges, or industry)	Active service on or after Sept. 16, 1940, and prior to July 26, 1947, or end of an enlistment period beginning between Oct. 6, 1945, and Oct. 5, 1946. Must have had 90 days' service; if less, discharge for disability incurred in line of duty. Discharge under conditions other than dishonorable. Minimum of 10 per cent service-connected disability causing a vocational handicap requiring training.	Training or school expense paid. Subsistence allowance $65 to $75 mo. if single; $90 to $120 with dependents. Minimum allowance plus disability compensation $105 if single; $115 if married. Amount varies with type of course, number of dependents, and degree of disability.	Veterans Administration regional office having jurisdiction over place of residence.
STATE VOCATIONAL REHABILITATION	Need for training to overcome vocational handicap due to disability. No service requirements.	Tuition, books, and tools for training; necessary treatment and appliances; and maintenance under varying circumstances are provided by joint state-federal funds.	State Vocational Rehabilitation Division—state capital city.

Type of Benefit	*Basis of Eligibility*	*Nature of Benefit*	*Administering Agency*
EDUCATIONAL PROGRAM (provided for by GI bill), (Public Law 346, 78th Congress, as amended)	In active service on or after Sept. 16, 1940, and prior to July 26, 1947, or to end of an enlistment beginning between Oct. 6, 1945, and Oct. 5, 1946. Discharge under conditions other than dishonorable. Service must have been for 90 days or more; if less, discharge for service incurred disability required.	One year's training or educational course. Additional period depending on length of service with maximum of 4 years. Educational expense up to $500 per year paid. Subsistence allowance $65 to $75 mo. if single, $90 to $120 with dependents. Amount varies with type of course and number of dependents.	Veterans Administration regional office having jurisdiction over place of residence.
REEMPLOYMENT	Service after May 1, 1940. Application for reemployment within 90 days after discharge under honorable conditions or hospitalization of not more than one year thereafter.	Reemployment under terms of Selective Service Acts of 1940 and 1948 if prescribed conditions are met.	Local office of Bureau of Veterans' Reemployment Rights or public employment service.
EMPLOYMENT	Service during a war period. Discharge under conditions other than dishonorable.	Job counseling and employment placement service for veterans and vocational guidance of disabled veterans through local offices of State Employment Service under general supervision of Veterans Employment Service.	Local office of State Employment Service.
CIVIL SERVICE PREFERENCE—FEDERAL (also provided by some states)	Active service in time of war or service-connected disability. Separation under honorable conditions.	Extra credit points on examinations and preference allowed under certain conditions.	U. S. Civil Service Commission regional office. (Information at local post office).

HOSPITAL CARE (provided by Veterans Administration)	Service during a period of war or a service-connected disability due to war or peacetime service, with discharge under conditions other than dishonorable. For nonservice conditions veteran must certify inability to defray expense.	Complete care in a Veterans Administration hospital, including transportation. Emergency care elsewhere may be authorized by VA for service-connected disabilities.	Nearest Veterans Administration hospital. (Authorization for admission should be obtained before patient goes to hospital. Veteran's physician can arrange by telephone in emergencies.)
OUT-PATIENT TREATMENT AND PROSTHETIC APPLIANCES	Service-connected disabilities requiring out-patient care or prosthetic appliances. Prior authorization required.	Treatment (including medications) by designated physicians. Prosthetic appliances furnished and repaired under certain conditions.	Veterans Administration regional office having jurisdiction over place of residence.
DOMICILIARY CARE—FEDERAL	Service during period of war or service-connected disability due to peacetime service, with discharge under conditions other than dishonorable. Must be so disabled as to be unable to earn a living and without adequate means of support.	Full care, including medical treatment in a Veterans Administration home.	Veterans Administration regional office having jurisdiction over place of residence.
NATIONAL SERVICE LIFE INSURANCE	Service in the armed forces on or after Oct. 8, 1940. May be obtained during service, or, if service was prior to Sept. 3, 1945, is available after discharge. Policy must be renewed or converted within 8 years of effective date if issued before Jan. 1, 1946, or within five years if issued later.	Pays death benefits according to mode of settlement selected. Pays $5 monthly for each $1,000 of insurance for total disability if disability provision is attached to policy. Waiver of premiums after 6 months' continuous total disability that begins prior to age 60.	Veterans Administration branch office having jurisdiction over place of residence.

Type of Benefit	*Basis of Eligibility*	*Nature of Benefit*	*Administering Agency*
CORRECTION OF MILITARY AND NAVAL RECORDS	Service during war or peace. Discharge may have been dishonorable.	Reconsideration of any military or naval record "to correct an error or remove an injustice." A new honorable discharge may be issued in place of dishonorable discharge when warranted.	Army and Air Forces: Board on Correction of Military Records. Navy: Board for Correction of Naval Records. Coast Guard: Commandant, U.S.C.G.
REVIEW OF DISCHARGE, SEPARATION, OR RETIREMENT	Service during war or peace and discharge or separation other than by general court-martial. Retirement for disability without pay.	Reconsideration of unsatisfactory discharge or separation or review of decision of retirement board. Change in type of discharge or separation or granting retirement pay, when warranted.	Army or Air Force Discharge Review Board; Disability Review Board in retirement cases. Navy Department's Board of Review, Discharges and Dismissals; or Retiring Board.
COMPENSATION FOR DEATH DUE TO SERVICE	When death while in active service was the result of an injury or disease incurred in line of duty. When death after discharge was caused by service-connected disability. Discharge under conditions other than dishonorable.	Widow receives $75 per mo. with additional amounts for minor children. One dependent parent $50 per mo.; dependent mother and father, each $35 per mo. (Above rates for World Wars I and II. Lower rates for peacetime.)	Veterans Administration branch office having jurisdiction over place of veteran's last residence.
PENSION FOR DEATH NOT DUE TO SERVICE	90 days' service or discharge for disability in line of duty during World War I or II. Discharge under conditions other than dishonorable. No other requirements for World War I veterans. World War II veterans must also have had service-connected disability for which pension would be payable if 10 per cent or more disabling.	Widow receives $42 per month with additional amount for each minor child. Income limitations. No benefit for parents.	Veterans Administration branch office having jurisdiction over place of veteran's last residence.

BURIAL ALLOWANCE—FEDERAL	War service, or peacetime service when discharged for disability incurred in line of duty, or in receipt of compensation for service-connected disability. Discharge under conditions other than dishonorable.	Maximum allowance of $150 for cost of burial and funeral expenses and transportation of the body.	Veterans Administration branch office having jurisdiction over place of death.
BURIAL IN NATIONAL CEMETERIES	Service during a period of war. Peacetime veterans qualify if in destitute condition at time of death. Honorable discharge from last period of service in all cases.	Burial in national cemetery. Under certain circumstances may also include wife, widow, or children.	Superintendent of nearest national cemetery.
BURIAL FLAGS	Service during a period of war or a complete enlistment, or discharged for disability incurred in line of duty. Discharge under conditions other than dishonorable.	American flag to drape casket and to be presented to next of kin at time of burial.	Nearest office of the Veterans Administration or county seat post office.
HEADSTONE OR GRAVE MARKER	Last service must have terminated honorably.	Uniform type of headstone or grave marker furnished free, delivered to nearest railroad station.	Quartermaster General, U. S. Army, Washington 25, D.C. (for all services).

Prepared for the information of ex-servicemen and women by the American National Red Cross, Washington, D.C.

Chapter 14 · HEALTH AND MEDICAL FACILITIES AND SERVICES

THERE IS AN UNEVEN DISTRIBUTION in the United States of the facilities, education and sanitary controls on which the development of health and medical services depend. The distribution is uneven when considered by states, by income groups, and by rural versus urban communities. A "fact sheet" [1] issued by the Federal Security Agency states that death rates from tuberculosis in a number of the states are only one-fifth or one-sixth as high as in the state with the highest rate. In 1943, the state with the lowest infant mortality rate reported thirty deaths per thousand live births; the state with the highest infant mortality reported three times that rate. The United States had in prewar years a much less favorable situation in this respect than a number of other nations. Six countries had lower infant mortality rates than we. At least seven countries had lower death rates among children and adolescents than the United States, and eighteen or more countries had lower death rates among persons aged 35 to 64 years. In the expectation of life for white boys at birth, the United States ranked fifth among nations in prewar years; at age sixty, the United States ranked thirteenth.

The unfavorable rural situation in the United States accounts in part for the relatively poor standing of the nation, when international comparisons are made. Here are a few summaries of recent data:

In 1945, the Interbureau Committee on Post-War Programs of the United States Department of Agriculture [2] reported that in most rural areas there were not 2.0 hospital beds per 1,000 population, whereas 3.5 or 4.0 per 1,000 are "probably adequate," and in cities 5.0 are generally recommended. About 450 rural counties had only privately owned hospitals, and those had only 1.5 beds per 1,000 population. More than 1,250 counties were without a single satisfactory general hospital.

For every 1,000 people in cities of 100,000 and over, 3,003 physicians' calls in home or office were received per year; in places under

5,000 and in the open country, only 2,240 physicians' calls were received. Also, specialists are very scarce in rural communities.

"While the general death rate of rural people is today still slightly less than that of city people, the decline in death rates has been much less in the country than in the cities," the Interbureau Committee report continues. The death rate among the infants and small children is higher in rural areas and small towns than in large cities. In 1942, the rate of infant mortality was one-fourth higher in rural sections than in large cities. "Maternal mortality (deaths of mothers in connection with childbirth) was almost one-third higher in rural communities than in large cities in 1941.

"Whatever type of needed health service is considered, less of it is received in the country than in the cities"—this seems to sum up the situation.

Why is this? There are geographic handicaps, sparse populations over great areas. Families living on separate homesteads are responsible for their own water supply and waste disposal. The cost per family is often high, considering family incomes. The benefits of the wide-open spaces are easily overemphasized, and construction of facilities has lagged. But the main reason is that rural areas, as we noted in Chapter 1, have not had the purchasing power of the towns and cities. Health must be bought, and low incomes simply purchase less health.

PUBLIC HEALTH UNITS

The "fact sheet" of the Federal Security Agency recorded marked expansion in the creation of rural agencies and facilities. For example, "In 1915, only 14 counties had full-time health services. Today [1946] 60 per cent of our 3,070 counties have full-time public health services." Yet in only four states was the entire area covered by full-time professional staffs. And approximately 40 per cent of the counties had public health service only under part-time or untrained health officers. The fact that a county had an adequate service did not mean that every portion was always covered.

Before 1908, Dr. Haven Emerson writes,[3] no county in the United States had a full-time public health official. In 1908, the health de-

partment of Louisville, Kentucky, began to render certain sanitary inspection services in Jefferson County, in which the city is located. In 1911, the city health officer of Yakima, Washington, began also to serve the county. In the same year, Guilford County, North Carolina, and the city of Greensboro began joint service. All these earlier efforts were influenced somewhat by city action. Dr. Emerson goes on, "In the following year (1912) the first county health department in an area uninfluenced by the proximity of a large city came into being. Robeson County, South Carolina, with a population of 52,500 and without any incorporated area of more than 2,500, appointed a trained physician as county health officer to devote all of his time to the duties of that office. Thus the Robeson County health officer should perhaps be counted as the first full-time rural health officer in the United States."

Development of Programs. By 1934, there were 541 rural counties with a full-time local health officer either in single-county or multi-county units. Then came the Social Security Act, with enlarged federal grants-in-aid, first of $8,000,000 and lately $11,000,000 annually, administered by the United States Public Health Service. This has resulted in rapid development, until by June 30, 1946, the Public Health Service reported that 1,842 rural counties had full-time professional service, through 988 units. There were 495 single-county units of organization, 148 city-county units, 694 counties in state health districts, and 505 counties in local health districts.[4]

There is no precise definition of what constitutes a city-county unit. Usually, it embraces one or more entire counties contiguous to a city, no matter what kind of contract is in force between the city and the county. Also, multi-county units present multiple arrangements. In some cases, two or more counties share a staff. In others, there is thorough and unified administration. Certain of these arrangements are regarded as temporary. In about half of the states one or more counties have the services available, but are not able to serve all sections. In June, 1946, there were 225 vacancies in the office of full-time health officer. One of the great difficulties throughout the years, accentuated during World War II, has been in the processes of training, enlisting, and maintaining personnel.

What do these public health units do? It is reported by competent authorities that in most states the public health services are "remarkably similar" and that the extent of the program in a local area depends largely upon the size of the budget provided. In the larger cities, the program tends to be relatively complete. For example, large cities operate tuberculosis clinics constantly for diagnostic work. The poorly financed county may be able to afford only an occasional clinic using a portable X-ray machine.

Six Basic Functions. The six basic functions of a local health department, says the Committee on Local Health Units of the American Public Health Association, include the following:

a. *Vital statistics*, or the recording, tabulation, interpretation and publication of the essential facts of births, deaths, and reportable diseases.
b. *Communicable disease control*, including tuberculosis, the venereal diseases, malaria, and hookworm disease.
c. *Environmental sanitation*, including supervision of milk and milk products, food processing and public eating places, and maintenance of sanitary conditions of employment.
d. *Public health laboratory services.*
e. *The hygiene of maternity, infancy and childhood*, including supervision of the health of the school child.
f. *Health education of the general public* so far as not covered by the functions of departments of education.[5]

What do the local units cost, and what are acceptable standards for budgeting? In 1936, 94 counties ranging in population to more than 500,000, having almost 34,000,000 people, spent $0.86 per capita for all public health services, of which only $0.52 per capita went for health department budgets. The counties with less than 20,000 population spent only $0.32 per capita, compared with $0.57 in counties with over 500,000 population. Expenditures per capita have been varying from $0.25 to $2.00 per year. One dollar per capita would provide reasonably adequate services in most situations. Two dollars provides excellent services.

A National Plan. The Committee on Local Health Units of the American Public Health Association has drawn up a plan whereby the 3,070 counties and the cities included in their boundaries could

be adequately served by 1,197 units of local health administration. In drawing up the plan, the Committee stated that in 1942 some 40,000,000 persons in continental United States were living in communities which had never undertaken to organize public health services or, if they were provided, they were under untrained, inexperienced, or part-time officers. Thus about one-third of the nation was living under substandard local health organization.

Certain principles which had grown out of past experience governed the shaping of the plan. These were:

1. No unit of population should be without access to or coverage by the services of a professionally trained and experienced health officer serving on a full-time basis.

2. Local responsibility for public health service is a primary essential of local government and should be so specified under state statute.

3. For administrative efficiency and economy, full-time local health officers should be employed for populations of not less than approximately 50,000 each, which units of population may be made up of single counties, several counties, joint city-county units, or parts of several counties when the natural transportation and trade movements so indicate.

4. The average distance from the headquarters of an area of local health jurisdiction to its periphery should not exceed 25 to 40 miles.

5. In creating units of local health jurisdiction, such factors as per capita income, persons per physician, and number of hospital beds per 1,000 population, should be taken into consideration. In developing district outlines an endeavor should be made to group counties so as to reduce large inequalities of per capita income by combining urban and rural, high and low incomes in a single jurisdiction where otherwise desirable. An attempt should also be made to group counties so that the ratio of physicians will be not less than one to 1,500 of the population and that general hospital beds available be not less than three per 1,000 of the population.[6]

Local Services Proposed. Haven Emerson explains that of the 1,197 proposed units, more than three-fourths agreed upon would have populations of 50,000 and over, and only 14 per cent of the units would have populations of less than 45,000. "More than one-fourth of the units include only one county, more than two-thirds are multi-county units; the remaining 5 per cent are made up of city

units or of units including parts of one or more counties." A unit of 50,000 persons should be able at a cost of about $1.00 per capita to employ the necessary staff and provide the basic services quoted above. There would be needed: "1 full-time professionally trained and experienced medical officer of health, 1 full-time public health or sanitary engineer, and a sanitarian of non-professional grade, 10 public health nurses, one of whom would be of supervisory grade, and 3 persons for clerical work." Part-time medical services could be purchased for specialized health conferences. It is assumed that state health department staffs would be available. The Committee recommends not less than one public health nurse per 5,000 population. If a community wished to provide both administrative public health nursing and bedside care of the sick, then not less than one nurse per 2,500 would be desirable. (Public health nursing is more fully considered in the next section of this chapter.)

The Committee states that because of local inaction, states are rapidly organizing public health services in manageable units. The choice between local and state control is declared to be "not far off." The need is great and is being publicly recognized. There is at present no serious demand for federal control. Therefore the Committee proposes that the county, as the local health administrative unit, undertake to provide service in both city and rural areas. Here is an opportunity for the smaller cities to take the initiative and find a way to organize these units which will retain local control.

One Unit's Experience. A study of the experience between 1920 and 1935 of two adjoining counties, the Brunswick-Greensville unit in Virginia, has been made by the United States Public Health Service. In the census of 1930, the entire area of both counties was classified as rural. A sanitation officer was first employed by Greensville County in 1920. A full-time health officer was employed for Brunswick County in 1924. The bicounty health department was organized in 1928. The staff at the time of the study consisted of a medical health officer, a sanitation officer, two public health nurses, and a clerk. Official headquarters were located at Brunswick County, with a suboffice in Greensville. The annual budget was $12,000 a year, 50 per cent of this amount coming from local sources. The program

was to a large degree influenced by that of the state health department. It included quarantine and isolation measures for control of communicable diseases, vaccination of school children against smallpox, an itinerant chest clinic, visiting nursing service in maternity and infancy hygiene, a tonsil clinic, an orthopedic clinic, and sanitation inspection.

An analysis also was made of the way the medical health officer spent his time for a period of ten months. Approximately 12 per cent of the 34,000 people received some kind of personal service. Immunization was given to 90 per cent of those receiving service, mostly to children of school age. Ninety per cent of the persons were reached through some group meeting conducted at schools. Control of communicable diseases was given special attention. About 10 per cent of the officer's time was devoted to control measures against communicable diseases, 15 per cent to immunization, 35 per cent to interviews and conferences, and the remaining 40 per cent to office and administrative duties and to specific health problems.[7]

Clinic Facilities Available. Preventive clinic facilities available in 94 selected counties have been described by the United States Public Health Service.[8] Of fifteen counties with populations of less than 20,000, only nine conducted clinic service of any type considered. Of fourteen counties with populations of 500,000 and over, all conducted clinics of fifteen types. Only one of the smaller counties conducted a cancer clinic and only one a heart clinic. In the largest counties, all conducted both heart and cancer clinics. "Lack of clinic service to support the educational work of public health agencies is an outstanding deficiency of health organization, especially for counties in the lower population group," say the authors, Anthony J. Borowski and Margaret Lovell Plumley. Few counties provide heart clinics, they found, unless the population exceeds 250,000. In the smaller counties, clinics are provided largely by public health agencies.

Dental programs in these 94 counties were studied by Joseph W. Mountin and Evelyn Flook. In 22 of the 94 counties, there was no definite provision for public dental programs through health agencies. "Areas without dental programs are largely rural."

Mental Illness. The health officer in a few states is being given increased responsibilities in the management of mental illness, the significance of which is becoming recognized. Dr. Daniel Blain told the 1946 National Conference of Social Work that about 6 per cent of the population suffers from mental disease or nervous disorder.[9] Medical opinion is tending to recognize that a high proportion of persons who are ill have an emotional disturbance as a factor in their illness. Examples of functions of health officers under state laws are as follows: New York State permits the health officer to assume temporary care of the alleged mentally ill, except in cities which have psychiatric wards in hospitals. The health officer may also obtain admission of such persons to a state hospital on his request. Oregon gives the health officer responsibility for temporary care. Arkansas authorizes the health officer to obtain admission of an acute case on request and certificate and also to start commitment proceedings. In Kentucky, Massachusetts, Missouri, Ohio, and Utah, the laws honor the health officer's request or order for temporary treatment of a person in a state hospital.[10]

Demonstrations. The demonstration method was widely used in the 1920s and earlier, by agencies interested in public health, to reveal what results could be obtained by thorough programs. Among these were activities in rural areas of New York by the Milbank Fund; in various states by the Commonwealth Fund; in Southern states by the Rockefeller Foundation. These especially influenced and encouraged the programs of state departments of health, which disseminated the results to other counties.

A recent example of a proving ground for public health work is that of Jones County, Mississippi, where a program has been carried out, financed in part by the Commonwealth Fund. An account of this has been given by Harry E. Handley and Caroline R. Randolph.[11] In eight years, $300,000 was spent from public and private sources, toward improvement in the sanitary environment—the safeguarding of milk supplies, for example. More than one-third of the health department's time was spent on children under school age. A large proportion of children under five years of age was immunized against diphtheria, a small proportion against smallpox. The

Commonwealth Fund contributed $10,035 toward a total budget of $24,500 in 1937; it gave $7,015 toward a total budget of $52,633 in 1944. The recent contribution of the fund has been only for the development of new services: nurse delivery, nurse-midwife, and immunization against whooping cough.

PUBLIC HEALTH NURSING

"The movement for putting nurses in the field is nationwide," George E. Vincent, president of the Rockefeller Foundation, reported to the national conference on rural health called by the American Country Life Association in 1919.[12] With the return to peace the American National Red Cross, through its town and country nursing service, was giving special attention to rural nursing and already had 307 nurses at work. It had offered scholarships to 275 young women who were taking training. Of the 8,180 public health nurses in active service, the large majority were in the large cities. The National Organization for Public Health Nursing was emphasizing problems of rural nursing and disseminating plans which assisted in organization. State tuberculosis associations were lending aid.

Dr. Vincent said then that the duties of the rural public health nurse were varied. She was "a health propagandist." She was the friend and counselor of the rural school teacher in dealing with education in hygiene. "The program of the rural nurse includes prenatal work, maternity care, baby welfare, hygiene and sanitation." The supervision of midwives was sometimes entrusted to her.

The movement to take public health nursing to the country received great encouragement from the federal-state program of maternal and child health, administered by the Children's Bureau under the terms of the Social Security Act, described in Chapter 5 above. By January, 1939, it could be reported that the total number of public health nurses employed by public agencies for all types of services in rural areas was 5,322, and that this figure represented a 50 per cent increase over that of eight years previous. But there were still 780 counties, about 25 per cent of those in the country, that had no rural public health nursing service.

The United States Public Health Service publishes annually figures

on the number of public health nurses in service, exclusive of nurses at work in industries. These figures indicate that during the war years there was considerable fluctuation in the number of rural nurses in service, but that in 1945 there were more nurses at work than in 1941, when calls from the armed services already were affecting all civilian nursing services.[13] During this time, however, the number of counties without rural public health nursing service increased steadily according to the annual count, from 679 in 1941 to 909 in 1945.

The Rural versus the Urban Situation. Joseph W. Mountin and Evelyn Flook reported in 1939 on the extent of public health nursing in 94 selected counties. They found that the extent of nursing service was directly related to the urbanization of the area. No public health nursing was reported in nine of the surveyed counties, and these all had less than 40,000 inhabitants. Nurses employed by voluntary agencies were practically all found in cities, and in rural areas nursing service usually was supplied by tax-supported agencies. "More than twice as many nurses per unit of population are employed in urban counties as in areas which are chiefly rural." Nurses of official agencies were reported to emphasize "instructive home service" rather than bedside care, the latter being emphasized by voluntary agencies in cities. This instructive home service was largely directed toward "control of transmissible diseases and child hygiene activities." [14]

Responsibilities of Nurses. In the intensive study of the Brunswick-Greensville area, referred to above, Pearl McIver describes the number and types of contacts and services rendered by the two nurses employed, one for each county, in 1935. The state health department supplied advisory service in the form of a visit by a nurse to each county about once every quarter-year. The state health department advised the nurses in the unit to give about one-fourth of their time to tuberculosis work; one-third to the maternal and infant hygiene program, including midwife supervision; and the remainder to other health problems. "Very little bedside nursing was done by the public health nurses, even as a demonstration." During one year, individual services were rendered to the number of 10,087, through

immunization clinics, school visits, home visits, office conferences, tuberculosis and orthopedic clinics, and nursing classes. Forty per cent of the "first visits to homes" were for the purpose of maternity care or instruction. With only two nurses for 34,000 people, "the service to the individual must necessarily be limited." The nurses always faced a dilemma—whether to try to reach the largest possible number of persons or to intensify the service rendered to relatively a smaller number of people. A tax-supported agency has certain general responsibilities that must be discharged "irrespective of other considerations." [15]

Throughout the nation, some of the more extensive services rendered by public health nurses have been those in connection with maternal and child health programs. Much of the federal, state, and local money budgeted in state maternal and public health nursing programs has been designated for public health nursing services. "An alert, well-trained public health nurse" is indispensable in all places, the Children's Bureau reported in connection with a development of the federal-state program, described in Chapter 5. The nurse is active, for example, in the child-health conference. A review of maternal and child health services of the Bureau states:

> One of her chief functions in the conference is interpreting the findings and advice of the physician to the individual mothers and making sure that they understand how to follow the instructions given. The nurse's conference with the mother is not a mere repetition of the physician's conference. It serves to enhance the total educational value of the visit. . . . The nurse [also] performs an invaluable function in direct teaching in the home. . . . Organized classes for mothers are proving valuable adjuncts to the teaching in the conference, and they enable the nurse to reach larger numbers of mothers than she is able to reach in individual visits. Her knowledge of and use of community resources helps to implement the work of the conference.

Day by Day Duties. Statistics on the large number of nursing visits for prenatal and postnatal care to mothers, as well as visits to infants, preschool children, and school children, "do not reveal the significance in the community of the continuing services of the public health nurse." The Children's Bureau statement goes on:

Day by day she makes parents acquainted with the health resources of the community—the prenatal clinic, child health conference, crippled children's clinic, tuberculosis and venereal disease clinics, hospital out-patient service—and with social resources such as welfare services and recreational facilities. After the baby's birth the nurse encourages the mother to return to the physician for the post-partum examination that may in later years mean health instead of invalidism due to neglect. Her intelligent observation of the baby and the child may lead to early recognition and treatment of potentially serious conditions.[16]

The educational qualifications of public health nurses in 1940 were reported by means of a large sample study which represented at least 95 per cent of the jurisdictions employing nurses. The study was conducted by Martha Derryberry and George Caswell for the United States Public Health Service. Of 2,846 county nurses reporting, 410, or 14.4 per cent, had not been graduated from high school; and 1,387, or 48.7 per cent, had had high school graduation only. The remainder had college training. In cities the situation was about the same. "Comparison with some of the previous surveys of the training of public health nurses indicates a gradual improvement in the educational background of the personnel." [17]

The Frontier Nursing Service. In four counties in the Cumberland Mountains of Kentucky, the Frontier Nursing Service, founded in 1925 by Mary Breckenridge, a nurse, has employed nurse-midwives who are able to practice midwifery. In the summer of 1923, Mrs. Breckenridge rode on horseback through the area and interviewed 53 midwives, doctors, teachers, and young mothers. The age of the midwives varied from thirty to ninety years, and the majority were past sixty years. Only twelve of the fifty-three could read and write. No nursing service was given. Mrs. Breckenridge went to England to receive training as a midwife in a London hospital—no such training was available in the United States. She also went to Scotland, where she saw nurse-midwives at work in the Highlands. On her return, she established the Frontier Nursing Service on the basis of the plans in use in Scotland. At first the service was carried on by British nurses and by American nurses trained in midwifery in England. Lately there have been six outpost centers, and a hospital

and a central administrative unit at Wendover. The service is supported by 4,000 contributors who reside in all sections of the country. Dressed in a uniform, the nurse travels on horseback for most of her duties. At each of the centers, one or two nurse-midwives live in a home which includes space for a clinic and a waiting room. Immunization work also has been emphasized. An auxiliary program is that of the social service department, which gives special care to dependent children and to the families of widows and of bedridden fathers.[18]

In the early years following World War II, rural public health nursing experienced its own peculiar aspects of the "national crisis in nursing, the nursing shortage." Not only in bedside nursing was there a shortage, in part because of low pay in relation to living costs. As early as July, 1945, 80 per cent of all state and local health departments, urban and rural, reported 1,313 vacancies in the position of graduate nurse, and this survey took no account of positions which were held for members of the armed services who were expected to return to their posts.[19]

SERVICES OF HEALTH AGENCIES

In actual practice, the services of the more specialized health agencies reach the rural population through the cooperation and mediation of the public health units described earlier in this chapter. We have noted, for example, the emphasis in those units on tuberculosis prevention and control and on maternal and child health. Likewise, the state departments of health stand in a unique relationship between both the national voluntary and public health agencies and the local units which serve about 60 per cent of the counties of the nation. Every state department of health is committed to the improvement of rural health facilities and conditions, but a great many of the state departments lack adequate means for carrying out an effective rural program.

Most of the state health agencies were originally called boards of health. The state health departments usually have certain supervisory and advisory functions, and delegate many important powers to the local units, counties, towns, townships, boroughs, and villages.

Despite variations in administrative setup, the basic services of most state health departments have become well standardized. The state health departments are intermediaries between national and local agencies, and have a great deal to do with determining the emphases in the local units. The American Public Health Association has made available a summary of the functions and services regarded as a minimum for state public health departments.[20] They study health problems and make plans for their solution. They give financial aid to local units as may be authorized. They administer state laws with respect to sanitation, control of disease, and public health. They maintain laboratory facilities. They encourage and coordinate local agencies and programs. They establish and maintain standards in local units. They gather and disseminate statistics. They mobilize available health agencies to meet emergencies.

The United States Public Health Service administers a varied but not yet comprehensive service, including grants-in-aid to states, cooperation with the state departments of health, and support of research. Among grants to the states are those of $11,000,000 annually, previously mentioned, for encouraging and maintaining county health units and those of varying amounts for venereal disease control, including the maintenance of public clinics. It administers a Negro Health Movement, which promotes National Negro Health Week with special lectures, conferences, and visits to clinics, and consults with many Negro voluntary organizations. It has promoted the education of nurses.

In 1947, Congress appropriated $7,500,000 to be used for the first of a series of annual grants for a mental health program. These funds are providing increased research, training of personnel, and support and stimulation of state efforts, particularly in prevention and early treatment. Grants are being made by the United States Public Health Service to public and private nonprofit educational institutions for training mental health personnel. A large proportion, $3,000,000, is earmarked for grants to the states for development of local mental health programs. One aim is to provide traveling clinics in order to bring services to the sparsely settled rural areas, which have had practically no facilities at all. The goal is to help to establish one

outpatient mental health clinic for every 100,000 of the population. Because of the shortage of personnel, these goals cannot be reached immediately.

Dr. Thomas Parran, when surgeon general, outlined a comprehensive national health program to meet the following objectives:

A sanitary environment for everyone;
A hospital system adequate for the provision of complete medical services for all;
Expanded public health services in every part of the country;
Augmented research in the health and medical sciences;
Training of health and medical personnel in adequate numbers;
A national medical care program.[21]

In explanation of the need for such a program, Dr. Parran states that control of milk-borne diseases would require the erection of 438 new milk pasteurization plants in 34 states. To give rural America adequate hospital facilities would require the erection of 2,400 well-equipped health centers in outlying rural areas, as well as the construction of many new general hospitals which would serve large areas. All counties, not only 60 per cent, deserve general public health services through units with full-time administrators, Dr. Parran goes on. Much new research is needed, particularly in heart disease, arthritis, cancer, and mental illness. Large funds are needed for adequate training of professional workers. Finally, Dr. Parran contends, there is need for social insurance as a method of payment of the costs of medical care.

In the pages that follow some of the rural services of other agencies and the progress made with respect to specific aspects of health service are briefly summarized.[22]

The National Society for the Prevention of Blindness reports that use of a prophylactic in the eyes of the newborn is mandatory in all but two states; reporting of cases of trachoma is mandatory in forty-two states. Thirty-five states require compulsory premarital and prenatal examinations as special protection for prevention of prenatal syphilis; examinations, including laboratory tests, are provided through a broad federal-state-local program, and any state health department can supply information on local facilities available. State welfare departments in twenty-five states are authorized to finance

corrective medical or surgical care of the "medically indigent"; rules for eligibility are available from these departments. Under the federal-state program already discussed, crippled children who are visually handicapped and require surgery are frequently eligible for public assistance. Thirty-two states make provision for establishing special classes for the "partially seeing," usually called "sight-saving classes," but rural communities generally do not have enough children to warrant holding such a class.

Twenty-one states make some provision for special education of visually handicapped persons outside their places of residence; seventeen states supply special educational materials and supervision for the handicapped child; the state department of education is responsible for administering the services. The society has carried on public education for the purpose of improving such services and standards. Marcella S. Cohen has described a special program in 31 school districts in Allegheny County, Pennsylvania. She comments that the generally accepted methods frequently do not work in rural areas, and that the visually handicapped child is a special problem. The Pittsburgh Branch of the Pennsylvania Association for the Blind purchased books with large type and loaned them to children as a demonstration. The program developed successfully, and recently there were thirty-eight children using special sight-saving equipment in the schools throughout the county.

The American Social Hygiene Association reports that it works through voluntary local affiliates but that these are, "in a majority of cases," located in cities of some size and probably do not serve directly the rural communities. In the states of New York, New Jersey, Connecticut, and Oregon, however, a social hygiene program is promoted by the state tuberculosis associations and their numerous county chapters, and these do reach and serve many rural communities. In the early years following World War II, there were many special county campaigns to stamp out venereal disease because of investigations made by the Association in 1,170 communities, near many of which members of the armed services were still stationed. For example, in the quarter from April to June, 1946, 16 per cent of these communities were rated "bad" and 28 per cent "poor," whereas in 1944, the last full war year, only 6 per cent of the

communities were rated "bad" and only 12 per cent "poor." Many citizens looked upon commercialized prostitution as one of the most serious dangers and worked toward its control. In this aspect of health work, the local public health units performed appropriate services of prevention and control, just as they functioned with respect to other health problems. These units aided in finding cases, in encouraging treatment, and in providing clinics.

Rural communities have been made aware, through the sale of "Christmas seals," of efforts to prevent and control tuberculosis and to encourage its treatment. The National Tuberculosis Association reports that the 1945 Christmas seal sale totaled $15,638,755, an increase of 4 per cent over 1944. School children contributed more that $500,000 through the purchase of double-barred cross pins. Ninety-five per cent of the proceeds of the Christmas seal sales are retained by the state and local associations for the support of their respective activities. The National office, among many activities, renders field and consultation services to aid the state and local associations. Recently the Association has made grants-in-aid to five counties in five states which had excessively high tuberculosis rates and which also lacked the services of effective tuberculosis associations and full-time professional staffs. The funds are being used to secure qualified personnel to direct the programs. These five counties are regarded as demonstration areas. The Association has now established a new department to handle the critical problem of recruiting and training personnel. The Association is constantly restudying popular educational materials in use and is supporting research. Negro workers in several local associations are reaching elementary school children.

The American Public Health Association, in addition to programs already noted, renders a service to local public units by conducting an Evaluation Project, which enables the unit to learn how its service compares with that of other units participating in the project. In recent years 18 states have taken part. The evaluation schedule is elaborate and is designed to reveal the health protection of the community as a whole. The data submitted should cover not only the work of the health department but that of private practitioners and voluntary agencies. In the 1944 report, officers of 243 local units in

32 states and four provinces of Canada submitted data for evaluation by the professional staff of the office of the Association. The Association conducts the project with and through the state departments of health. The result of the whole process is a compilation of health practice indices, which have become a valuable asset in state and local administration. When the final ratings are published, each unit is given a number, but the name of the unit is not published. The Association transmits to the local unit the number assigned to it, so that it can learn its standing in accordance with the indices used within the county; then the results on the rating scale may become a spur to community action and a guide to practices generally regarded as good.

The American Heart Association disseminates knowledge concerning the causes, treatment, and prevention of heart disease, and it promotes efforts for improvement of institutional facilities for heart-disease patients, among other functions. Originally a professional organization, it has broadened its objectives in order to meet the urgent need for national action regarding the social, economic, and medical aspects of heart disease. There are affiliated regional, state, and city associations. These associations are engaged in furthering community programs for treatment and prevention, in scientific programs, and in health education activities conducted with the lay public, local agencies, and physicians.

Mental hygiene clinics are reported by staff members of the National Committee for Mental Hygiene to be, with few exceptions, urban phenomena. The limited number of rural clinics available are arranged by brief visits of physicians to an area. The services usually are for diagnosis only. No sustained program can be provided by these clinics.

Much health education and nutrition work is carried on by the local home extension agents at work in more than 2,500 counties. These agents reach more than 2,000,000 women and girls a year, largely, but not exclusively, among the farm population. Their educational programs are on many aspects of home-making, but health and nutrition have important parts. The Extension Service of the United States Department of Agriculture is ready to advise with state agricultural extension services concerning their own activities

in relation to rural health. A special national coordinating program in nutrition also has been administered by the Department of Agriculture during the war and the early postwar years. This program has been largely educational in nature. Through all the interested agencies it has directed attention to practical problems as the use of relatively new nutritious foods, including soybeans and the enriched flours; the adaption of available foods to the prevailing food preferences; the use of foods temporarily in good supply in place of those not available; and the proper feeding of families. Nutrition committees have functioned in all the states. There was much evidence that during the war the nutritive value of the entire food supply used by the nation went to the highest point ever attained, this along with huge exports to nations in need. Increasingly, rural citizens were learning nutrition in a practical way.

In North Carolina there has been organized a state-wide, voluntary Good Health Association, which aims to promote action for erection of adequate hospitals and to improve all health facilities. It is asking communities to provide clinics and hospitals as living war memorials and to prepare themselves for receipt of grants under the Hospital Construction Act of 1946, which has authorized the expenditure of $75,000,000 a year for five years in states that will put up $2.00 for every federal dollar and also submit approved plans to the United States Public Health Service. Both voluntary nonprofit and public hospitals will be eligible to receive federal funds.

MEDICAL CARE

The need for better medical care in rural communities already has been mentioned. The lack of physicians often is roughly correlated with the lack of hospital facilities. Plainly, the trained practitioner on leaving medical school finds rural practice unattractive. There has been a high degree of shifting among rural physicians. Despite improved transportation enabling fewer doctors to cover wider territory, it can be definitely stated that the quality of medical care available to rural dwellers is far below that of cities generally. Dr. Thomas Parran told the 1945 National Conference of Social Work [23] that there were 141 counties in which there were more than 5,000 persons per active physician, and 81 counties with no active physi-

cian. Almost all of these counties were rural. Whatever is said about rural communities applies with special force to the Negro minority. Negro death rates in 1940 were 71 per cent higher than white; in 1942, Negro maternity mortality rates were 150 per cent above those of whites, urban and rural, with all available data indicating a less favorable situation in rural than in urban communities.

Everybody agrees that better medical care is needed by most rural people. But *how* shall it be provided? Here come schools of thought. A ferment of discussion has arisen, both within and without the medical profession. Consumers are asking to be heard. The uneven distribution of medical care is now generally regarded as not wholly a medical problem, and people other than physicians are asking for a voice in bringing about changes. And changes are not merely being discussed—they are in process.

Importance of Hospital Construction. The importance of hospital construction is emphasized by the fact that the counties which in 1938 had 250 or more beds per 100,000 population had about two and a half times as many practicing physicians as those counties that were without general or allied hospitals, according to Dr. Parran. If hospital construction can be speeded, presumably the auxiliary movements for provision of physicians would also be encouraged. Congress has authorized a national-state hospital construction program which will include hospitals for rural as well as for urban people. If all states cooperate for a period of five years beginning in 1947, there will be expended a total of $1,125,000,000 under the Hospital Construction Act of 1946. Dr. Parran has estimated, however, that this authorized program will provide only a small start to meet the need. He states that about $4,000,000,000 would be needed to establish a complete country-wide network of "workshops of medicine."

The United States Public Health Service has prepared a national plan, stating that "heretofore hospitals have not been planned in reference to total community needs." Careful estimates indicate that the nation needs about 166,000 beds in general hospitals, 191,000 beds in mental hospitals, and 44,000 beds for tuberculous patients. Many new general hospitals, centrally located, should be built. These

would be related to the really large hospital centers—the base hospitals. Farther away from the base hospital than the general hospital would be a series of small rural hospitals. At the periphery in the rural areas would be a system of small health centers—"the field stations of the future medical system." [24]

At the rural hospital there would be provision for internal medicine; obstetrics; eye, ear, nose, and throat treatment; dentistry; minor surgery; laboratory in X ray and bacteriology. (Major surgery would be carried on at the larger general hospital.) The outposts would be health centers, providing for both medical care and public health services in one building. Persons interested in public health have long expressed the need for adequate buildings so that the office of the county health unit could be moved out of the courthouse basement—where it frequently is housed. At the outpost there would be housing for medical care facilities, including obstetrics and emergency medicine and surgery; a laboratory; dental offices; and private offices for private physicians.

Plan for Coordinated System. An announcement by the United States Public Health Service sums it up as follows:

> Big city medicine will go to the country when met half-way by rural health planning in a coordinated hospital system. This will bring modern medical practice to rural areas much more effectively than is now possible under the present system of unrelated hospitals.
>
> There are four principal elements in a coordinated hospital system.
>
> 1. The medical center, containing the most comprehensive facilities for medical research, basic teaching, diagnosis and treatment.
>
> 2. The district hospital, represented by a large, well organized general hospital furnishing a comprehensive type of service.
>
> 3. The rural or small suburban hospital, capable of handling the average types of medical, surgical and obstetrical cases.
>
> 4. Health centers, strategically located throughout the entire area, to provide public health services, health education, and emergency service.[25]

For the 3,070 counties of the nation there would be, in all, 760 hospital districts, an average of four counties per district. This takes no account of some 2,400 rural health centers on the periphery. The planning of such regions is not a precise process. C. Horace Hamilton

has generalized his studies for the Commission on Hospital Care by stating that "as population thins out, the hospital areas get larger and population per community gets smaller . . . There must inevitably be a compromise between the size of the hospital service area and the size of the hospital . . . Yet, even with good transportation, distances greater than 25 miles constitute a serious barrier to frequent hospital use. . . . The small health center, if closely affiliated with the hospital, would relieve the hospital of many simple cases and in return send the more complicated cases to the hospital." [26]

Local General Hospitals. Beginning with the action of Iowa in 1909, most states have authorized local governmental units to construct public general hospitals. "Rural community hospitals have become common," Wayne C. Nason reported in a Department of Agriculture Bulletin in 1926, yet he quoted many who referred to "further need of rural hospitals." [27] In 1937, the United States Public Health Service conducted an inquiry to learn the financial support of hospitals controlled by local governments. Data were gathered from 511 hospitals controlled by local governments, mainly cities and counties. One conclusion was that all local hospitals with a bed capacity of less than fifty derived considerably more than half their income from direct payments by patients. For all sections except the West, hospitals located in counties of less than 100,000 population received from three-fifths to three-fourths of their income from fees from individuals. Local governmental hospitals with less than fifty beds, located in counties having less than 40,000 people, received 78 per cent of their income from fees of patients. Previous studies of voluntary hospitals were compared with these results of the public institutions. It was stated that the governmental hospitals in the smaller counties received from their patients "practically the same proportion of their income as do non-profit hospitals." [28]

Noting that "when hospital facilities are missing, medical progress lags," the Commonwealth Fund in 1925 offered to meet two-thirds of the cost of building and equipping a limited number of hospitals for which communities would themselves provide "suitable sites, responsible management, and the necessary maintenance." Awards

were made only after needs had been confirmed by field study. "The hospitals so offered were to be community general hospitals—held by local non-profit corporations as a public trust, admitting patients without restriction as to race, creed, color, or economic status, open to all physicians in good standing, and equipped to serve patients suffering from as wide a range of disorders as the local physicians were competent to treat," Henry J. Southmayd and Geddes Smith have written. Most rural communities they knew were not familiar with that type of institution. Many small hospitals were privately owned by individual physicians or groups of physicians and operated for profit, "though often at a loss." Under the plan thirteen awards were made. Most hospitals built had some fifty beds. The people applying wanted small hospitals close at hand. However, a unit was arranged in which it seemed reasonable that people within a radius of 25 to 35 miles would freely use the hospital.

Summing up the experience of this "baker's dozen of hospitals," Southmayd and Smith cite the record as showing that "a rural area having from 50,000 to 100,000 people, even if it spreads across county lines, *will* make effective use of a single central institution. . . . If 50,000 to 100,000 people will use a single hospital placed at the natural center of a homogeneous trading area, they can have about as good a hospital as the same number of people in a single city could expect to have, and a far better one—both in physical equipment and in professional resources—than any single small town or its immediate neighborhood are likely to be able to support. . . . The rural district hospital is at least a practical possibility." [29]

Various Approaches. In the Upper Penninsula of Michigan, the Children's Fund has provided the Northern Michigan Children's Clinic, which functions as an adjunct to a general hospital.[30] It provides facilities for children eligible for benefits under state laws, particularly crippled children, and medical care for the indigent children of a remote area. Recently there has been expansion in the form of a child guidance clinic under the sponsorship of the State Hospital Commission and the development of a rheumatic fever program conducted in cooperation with the Crippled Children's Commission. Both these services receive federal funds under the provisions of the Social Security Act (see above, Chapter 5).

The New England Medical Center at Boston has a well-established plan by which the Tufts Medical School hospital serves as a reference group for certain of the small hospitals in Maine. By this method, the small hospitals send to Boston patients who present difficult problems. Physicians from Boston visit the Maine hospitals at regular intervals. Physicians attached to the Maine hospitals also are sent for training to the hospital center in Boston.

The Commonwealth Fund assisted in the organization of a council of regional hospitals near Rochester, New York. Seventeen hospitals are members, eleven outside the city. Nurses from the small hospitals are sent for special training to the larger hospitals. Specialists from the School of Medicine of the University of Rochester go into the region to conduct clinical teaching conferences. Internes from the larger hospitals in the city spend some time at the small hospitals. A council on a smaller scale has also been organized in southeastern Virginia, around the Medical College of Virginia at Richmond.

The Kentucky Medical Association and the School of Medicine of the University of Louisville sponsored in 1947 a special financial campaign to raise $100,000, with which to grant aid to medical students who promise to practice for a period in rural communities. The campaign was unusually successful—$150,000 was raised. The public was much impressed by statements made in the campaign to the effect that in the near future there would be only one doctor to more than 4,000 persons in rural communities of Kentucky.

The Commonwealth Fund financed an experimental course in psychiatry at the University of Minnesota for general medical practitioners. Courses were given on personality development and disorders and on elements of psychotherapy.

The Rockefeller Foundation assisted the Bingham Associates Fund in the development of a program of postgraduate medical education in certain rural areas and towns in Massachusetts for a five-year period.

The College of Physicians and Surgeons, Columbia University, and the Mary Imogene Bassett Hospital, Cooperstown, New York, have inaugurated a program which provides an opportunity for medical students of the University to make first-hand observations

of the conditions under which physicians in small towns and rural areas work. The College of Physicians and Surgeons will from time to time assign medical students to serve as clinical clerks in the Hospital for periods as may be mutually agreed.

The W. K. Kellogg Foundation has made a three-year grant to establish a plan to train rural nurses among the students of Keuka College, Alfred University, and Hartwick College, all in the state of New York. It is known as the Rural Collegiate Nursing Program.

The Farm Foundation is giving special attention to the means of improving the medical care of rural people.

American Medical Association Programs. The American Medical Association Committee on Rural Medical Service has published a pamphlet [31] stating that "the medical profession is vitally concerned with the health of rural communities." The first step in applying a remedy is to find out where medical service is lacking. When the need has been discovered, the remedy can be sought in any one of several different ways. "Physicians cannot be forced to locate in any community; rather various methods should be used in making such communities sufficiently attractive so that qualified physicians will go voluntarily." One of the recognized needs is for the establishment of what has come to be known as the health center. (Here the committee offers a definition which corresponds to that used by the United States Public Health Service, as given above.) Item Five of the National Health Program of the American Medical Association is quoted, as follows:

> The provision of health and diagnostic centers and hospitals necessary to community needs is an essential of good care. Such facilities are preferably supplied by local agencies, including the community, church and trade agencies which have been responsible for the fine development of facilities for medical care in most American communities up to this time. Where such facilities are unavailable and cannot be supplied through local or state agencies, the federal government may aid, preferably under a plan which requires that the need be shown and that the community prove its ability to maintain such institutions once they are established. . . .

There is a reference to the Hill-Burton Bill, which was passed and became the Hospital Construction Act of 1946.

The committee then says that state and local medical societies can aid in understanding the nature of a local medical problem, that health education is urgently needed in rural communities, and that individual physicians can carry out educational programs. Twenty-six state medical societies have formed rural health committees, which aim to implement a rural health program. The Ohio State Medical Association states, for example, that "support should be given to efforts to find the solution for existing health problems in rural areas. . . . Increased efforts should be made to attract physicians to such areas." Organized medicine opposes public systems of insurance for prepayment of medical care. It has favored nonprofit systems such as the Blue Cross for prepayment of hospital expenses and has approved inclusion of plan for prepayment of physicians' services in connection with hospitalization.

The Blue Cross System. The Blue Cross system began in a city-wide plan in Sacramento, California, in 1932, although local hospitals had demonstrated the method earlier, the first being the University Hospital at Baylor, Texas, in 1929. The subscriber makes small regular payments to a fund and in return is assured benefits under certain conditions. Practically all plans provide for full hospital benefits for 21 to 30 days a year or for each admission. In 1945, Louis Pink reported that more than twenty Blue Cross Plans were actively enrolling village and farm people.[32] He estimated that 1,000,000 members of farm families were included in some plan, and of these about 500,000 were in the special program of medical care organized by the Farm Security Administration, discussed in Chapter 7. In 1940, there were 5,000,000 subscribers to the Blue Cross Plans; in 1947 there were over 22,000,000. Many attempts were being made to give additional benefits in the form of prepayment of doctors' bills for services furnished in a hospital.

Efforts through Cooperatives. Cooperative medical care associations are linked together in the Cooperative Health Federation of America. Officers of the Federation state that only about one per cent of all the forms of voluntary insurance for medical care are actually consumer-controlled. There are about twenty health cooperatives that attempt to bring better medicine to people. An example is the

South Plains Cooperative Hospital at Amherst in northwest Texas. The fee for medical service, exclusive of hospital bills, is $25 a year for a family of four, after payment of a membership fee ranging from $50 to $100. The Texas Legislature in 1945 passed a law authorizing the chartering of cooperative health associations. Texas farm people echo what many others have said—one of the best methods of getting doctors to the rural areas is to have a hospital. Physicians are paid salaries and have their offices in the hospital building. Following the example of Texas, the legislature of Wisconsin recently provided for the chartering of cooperative health associations.

A compulsory system of social insurance for prepayment of medical care has been agitated, and in 1946 the Senate Committee on Education and Labor held hearings on a bill. However, Congressional leaders announced in 1947 that no consideration would be given to a measure of this type by the Eightieth Congress. It was expected that the Eighty-first Congress would again consider a bill.

Chapter 15 · STATE ORGANIZATION

STATE AGENCIES, both governmental and voluntary, are in positions of peculiar responsibility in the process of rural social welfare. In all states, public administration of old-age assistance, aid to the blind, aid to dependent children, and certain child welfare services is well established by statute. In other programs, the influence and supervision of the state department of welfare are of great importance in public education, extension of services, and the gradual acceptance of standards by local units. In a few states, voluntary organizations of citizens concerned with the stimulation of local effort have been very effective; these are noted in this chapter.

Social Welfare in "Spring County." A story entitled *Organizing a Public Welfare Committee in Spring County* [1] has been told by Margaret F. Byington. "Spring County" (not its real name) is in the state of New York. It has an area of more than 1,000 square miles and a population of about 150,000, of whom approximately 80 per cent are native born. It has one large city of 90,000 people, given the name of "Centerville" in the account, and "extensive rural districts." There are twenty-four townships and six incorporated places with populations from 3,000 to 12,000.

The record has to do with the visits made in 1937–40 by two members of the staff of the State Charities Aid Association, which had declared in a statement on "The Public in Public Welfare": "Citizen participation, long accepted in other fields of government such as public works and education, is finding a new focus in public welfare. It is being secured through organizations which are familiarizing the citizen with the work of local welfare agencies and giving him a voice in charting their progress." The Association, despite its name, is not connected with the state government and does not receive any public funds. Its activities are financed by voluntary contributions, and it offers the services of its professional staff without charge to local committees. Of these committees there were recently 107 in all parts of the state. The State Charities Aid Association has more than 10,000 members.

Before the visits in 1937–40, "the State Charities Aid Association had been active in the development of citizen interest in Spring County in a number of fields, especially in tuberculosis prevention and in the care of dependent children." Between 1909 and 1916, the State Charities Aid Association had been largely instrumental in organizing a service for the care of dependent children. In 1909, the Association had a part in persuading the county to pay $900 a year for the salary of a children's agent. A year later, a second person was employed. Between 1912 and 1916, the Association representatives gave supervisory service to the agents. From 1916 to 1917, field workers of the State Charities Aid Association had had only occasional contacts with the Commissioner of Public Welfare. In 1937–38, the Association presented a plan for organizing public welfare committees in the state. Thus "Jane Doe" was sent to Spring County to start the process of organizing a committee there.

First Jane Doe called on public officials, who thought it would be good to have an interested citizens' committee. Next, contacts were made with private citizens. Jane Doe then reported their comments to the public officials. The state department of public welfare was informed and expressed interest. The judge of the children's court was doubtful—he thought citizens might become "hypercritical of public officials." A Catholic priest and a Methodist minister were favorably inclined. Then interest was "sought throughout the county." Plans for a preliminary meeting were made. Fifty-nine persons appeared for a luncheon meeting on a day in December, 1937, even though there was a blizzard which lasted all day. Eight communities were represented. About half of those present were social workers or public officials, the other half being lay people representing various organizations and the press.

Early in 1938, Jane Doe was succeeded by "Ann Roe," who made a visit of three days and another of ten. She saw fifty-four persons. By May, 1938, there were a temporary committee and an executive committee. For chairman, the group had selected a man who had been "rather quiet" in the course of the preliminary discussions. The State Charities Aid Association approved the preliminary work, and a general committee was organized, forty-three persons paid mem-

bership dues of $1.00 a year, and fifteen others said they would become members. Informal social study of the county welfare department and of other county services followed. Soon there was a subcommittee on child welfare. The executive committee later made a proposal that a child welfare supervisor be appointed. The county public welfare committee also approved a plan for a unified county welfare department, to replace the town welfare officials, a procedure later provided by state law.

State Citizens' Organizations. This sequence has illustrated a method of the State Charities Aid Association in the development of social welfare agencies and institutions throughout the state of New York. Another state-wide citizens' organization is the Public Charities Association of Pennsylvania, with a membership of over 7,000 persons. It, too, has emphasized fact-finding by citizens. It publishes a weekly bulletin for its members while the state legislature is in session. The several divisions and committees on Family and Child Welfare, Mental Hygiene, and Penal Affairs all carry on study projects and promotional activities. Once the Association developed a ten-year program on child welfare for the state. Other state-wide citizens' organizations which engage in planning for meeting social welfare needs are the Delaware Citizens Association, the Indiana Civic Association, the Massachusetts Civic League, the Ohio Institute,[2] and the New Hampshire Citizens Council for the General Welfare.

State Children's Aid Society. One of the older voluntary state agencies that has done both urban and rural work is the Children's Aid Society of Pennsylvania. Under the terms of its charter, it was formed "to provide for the welfare of any destitute children who may come under its control . . . and to aid and cooperate in the protection of children from cruelty." In August, 1946, 1,206 children were in the care of seven of the county branch societies. In these counties there are both urban and rural communities, and the services are available to both. There is probably some tendency for cities to know more about available services and to accept them more readily. Of the 1,206 children in care, 849 were in boarding homes and 196 in institutions. In the same month, 527 foster homes were in

use. The county branches receive funds both from voluntary sources, through community chests and parents and relatives, and from governmental units for which services are rendered.[3]

State Conferences of Social Work. State conferences of social work or of social welfare provide forums where urban and rural social workers may come together and where, apparently increasingly, many lay persons meet with professional social welfare workers. In September, 1944, there were 46 state conferences. Thirteen state conferences had full-time paid secretaries. Of 32 replying to an inquiry by Arthur Dunham in 1944, 21 stated that they definitely endorsed or promoted legislation.[4] Several state conferences promote district or county conferences. The main function is usually an annual meeting of about three days.

State Public Welfare Departments. As for governmental state agencies, we have reviewed the functions of state health departments in Chapter 14, and now should consider the role of the state departments of public welfare. They have emerged only recently out of a somewhat chaotic past. As we noted earlier, the tradition in the United States has been to rest authority with the local govermental unit, where there was a tendency to restrict any aid to residents, where family responsibility was stressed, and where public aid was given in such a way as to be at least so distasteful that independence and self-support would be thereby encouraged. In certain instances, the states assumed the task of administering institutions for the care of the insane under the authority of separate boards. In others, the states set up unified boards or agencies that administered these institutions. Then came the development of other types of social institutions for delinquent, deficient, or dependent persons, and "state boards of charities" came into being, beginning with that of Massachusetts in the midst of the Civil War in 1863. In these boards were the origins of what are now usually called departments of public welfare or social welfare or social security. The Social Security Act of 1935 stimulated the systematic organization and reorganization of these departments, when the states undertook new responsibilities for administering the federal grants made available to cooperating states. Thus a federal act helped to shape state public welfare departments as they are today.

Supervision and Other Functions. The general principle of state supervision of local welfare service gained acceptance in the early 1930s as a result of the varied state activities for unemployment relief. Many states made grants to local governments. The state legislatures attached certain conditions to the grants. A state agency was generally given authority to issue regulations and to enforce standards. This usually implied inspection and supervision by state staffs. Then the Social Security Act brought new programs which consolidated the previous trends and arrangements. Every state wishing to cooperate was required to submit its plans for approval by the Social Security Board. The Board required adequate supervision by state authority.

As for the other types of services, "great variation prevails from state to state," Wayne McMillen has written.[5] To a wide extent, the effectiveness of the state department of welfare, in relation to local units, is determined by the size of its budget and by the extent to which the state participates by means of grants-in-aid. Since local units in the United States have been distinguished for their localism, state agencies must use their authority wisely if they would be influential. Still, the state agency is generally in a position of influence even if its legal powers are slight. Its staff members can persuade. They can make studies that show comparative performance. They can make valuable suggestions. They can give indirect leadership and direction. They can help to educate lay leaders. They can supply perspective and inspiration in their contacts with local professional and volunteer workers. Professor McMillen further states: "The attitudes of the field agent . . . provide an index of his capacity to serve the counties. Of basic importance is a willingness to start with any community at its own level."

The Role of the State Field Worker. A decisive role in the improvement of rural social welfare programs is thus cast for the field worker from the state public welfare office. If a county has expressed some genuine desire for a service, Mary Clarke Burnett writes, the state worker "can proceed to explore the problem" and can give the results to the county. But "will the results of such exploration be accepted on the basis of the worker's testimony alone? An alternative approach is to ascertain from those most likely to be concerned

what they think about the situation and the degree of their interest in using the help the program has to offer. The worker's task then becomes one of studying the county rather than its dependent children, and this requires the ability to evaluate the forces that mold opinion and determine official action. . . . The opposing factors cannot be overlooked." The professional from the state office "may be tempted to manipulate or control the situation." Experience indicates a better way—to "rely upon the right-thinking members of the community to carry the program through" after they have had all the professional aid that can be given them.[6]

Rural social workers have relatively few opportunities for conferences, professional contacts, or in-service training, and sometimes they develop feelings of inferiority because of these limitations, writes Minnie Alper on "Supervision in a Rural Setting." The state worker has the opportunity to break down the fears of isolation. On the positive side, rural social work has brought to many professionals "opportunities for creative effort" and for executive experience. Possibly "a new group of workers who prefer rural living" may become interested, and then the competition from urban areas for experienced rural workers may lessen.

A special service is rendered by the state supervisor in giving the local worker an opportunity to talk with "someone outside the situation." If the state worker can be trusted and has the necessary perspective, the local worker will be able to clarify his own thinking, see the worth of individuals involved, and consider the value of his own versus their judgments. Sometimes the local worker needs someone to whom to express his "negative feelings" before going on to the constructive aspects of a professional interview. A small community may develop an intense feeling against one delinquent child or a drunken father, so much so as "to require extreme strength on the part of the worker to remember the needs of the client and to preserve his own professional integrity." The state field worker may assist the local worker to acquire "the ability to work toward a goal and yet be flexible in accepting present limitations." Social work by professional workers is still new in most rural communities. "Techniques must be adapted to encompass the personal relationships," Miss Alper concludes.[7]

Chapter 16 · PLANNING TO MEET FUTURE NEEDS

"WHAT DO RURAL WORKERS actually do that is different?" a rural social worker was once asked. Josephine Strode, of Kansas, made this quick reply. "Do? Do? They do everything and most of it without benefit of anything but their own integrity and ingenuity." She pulled from her brief case a list of the duties of the county social welfare workers of Kansas. It was "pages long." Then Miss Strode added, "It isn't what they do that worries them, but how to do it better." [1]

Rural social welfare activities are extensive in a few types of work, as these pages have revealed, even though rural America may still be the frontier of organized social work. The federal-state public assistance programs undoubtedly have improved standards of work, have made available new funds, and have brought a degree of helpful supervision hitherto not available. The federal-state services for children have demonstrated effectual means of meeting dire needs of those who especially deserve the nation's attention. Certain Red Cross services are actually national, handled largely by volunteers in the rural chapters. Voluntary agencies are extending services gradually, mainly by a search for larger and larger units of local administration. Public health facilities have come to more than half the counties, largely through the stimulus of federal grants-in-aid. Public health nursing is one of the well-accepted activities. Rural communities are recreation-conscious. Churchmen are searching the heart and initiating projects, as well as saying a good word for many organized activities.

Rural public opinion is still explained in terms of paradox. The rural people often say that they do not like or want social welfare services—yet daily the need for these services is more deeply impressed upon them, and gradually more and more people roll up their sleeves and work to secure or maintain activities. Low salaries for social workers prevail, but all professional salaries are lower in

rural than in urban places. Yet the rural task demands great skill and superhuman wisdom. No matter in what agency, the worker is inevitably somewhat of a general practitioner. The case workers say that they have "an undifferentiated case load." Flexibility is the watchword in the rural social welfare world.

State war funds enlisted many rural leaders in the raising of budgets for the great war causes, and local agencies were encouraged to combine their own budgets with those of the special funds. But Harold Amerman summarized the experience of a number of people to the effect that the leaders of rural areas were not generally aware of either social needs or the possibilities of organization to meet them.[2] Rural social planning is a slow process, he reminded. Yet he could report in 1944, for example, more than one-third of the counties of the state of Illinois had some type of community chest. In rural communities the situation was less favorable than in cities—the public had not yet recognized that social welfare agencies were providing through a profession many essential public services.

"WHAT IT TAKES"

It takes a good deal to do rural social welfare work, and the rural workers sometimes desperately need general recognition of what it takes. Josephine Strode has outlined the task in *The County-Worker's Job—What It Is and What It Takes* out of experiences in county welfare offices. In the process of "doing everything," Miss Strode notes, rural workers feel the need "for special skills to help them not only with case work but with office management, personnel supervision, publicity writing, community organization, budgeting, clerical procedures and group leadership. Skills for us, however, must be based on an understanding of the realities of rural life. . . . As to group leadership, I don't know of any book that could prepare a social worker for the kind of things we meet in a rural community. Books give us philosophy, of course, and an idea of basic techniques, but it takes practice and quick thinking and gumption to start with to adapt them to circumstances."

On a bitterly cold night there was a meeting at Prairie View, where the social worker was to go over new regulations. Miss Strode describes the meeting place as an abandoned one-room depot where

a pot-bellied, hot-blast stove furnished the heat. A table for one was at one end with chairs in rows down the length of the room. As the hot-blast stove went into action, the people near it began to mop their faces, while those near the loosely-boarded walls were blowing on their chilly fingers. Soon there was much moving about and changing of seats and, of course, inattention. "I was slow to comprehend that this was a cooperative demonstration of sharing the heat and the cold. I despaired of the success of the meeting until I thought up a group technique of my own to keep people hot and cold in the same places at the same time. We moved the chairs into a circle around the stove, and thus achieved some integration, a uniform heat-in-the-front and cold-in-the-back condition, which is the best you can do with a hot-blast stove."

Rural social workers are all working out techniques of their own, but these are not known to others, Miss Strode went on. "To retain the best in developing practice and to evolve better and more scientific procedures, we must engage in that good old-fashioned, sometimes belittled, business of cooperation. We need to pool our experiences. . . . Our days are too busy, our lives too full of pressing obligations, to tackle every problem in a trial and error fashion. We need the benefit of the experience of other rural social workers, both successes and failures." Miss Strode herself has compiled her own principles and practices of rural social work.

"Publicity by Way of the Barn Door—Catch Your Community Where You Find It." The tools of publicity are the same in rural as in urban areas, but the tempo of life is not. In western Kansas, during a long drought, the farmers had been waiting six years for a crop. Once an executive who thought he was "quick thinking," and who, on meeting with the county commissioners, was amazed at the length of time they could "jest set," did not realize that they were not "jest settin'. . . . They undoubtedly were 'sensing' him out just as surely as if they had asked him a flood of questions. Rural people have their own preferences for language, too, which all who do publicity please study."

"Learning from the Job—Every Experience Has a Meaning of Its Own." The rural social worker has a better breakfast than her city cousin, then "she pushes off down the road in her old jalopy."

The rural workers, being generalists, often hesitate to contribute to intricate discussions of specialized social work theory at professional conferences. They are apt to let their minds wander and "turn back to figuring out how to get old man so-and-so to patch his roof before winter." Rural social workers are not impressed by the "constant hammering" on the necessity "of formal professional education." Anyway, they might as well "reach for the moon" as think about getting away for a year or two of study.

"Getting Along with the Bosses—They Need Understanding and So Do We." As for bosses, "there are so many of them." In one county office, twelve or more welfare services are administered. Night and day the supervisors from the state offices may descend on the county workers. Sunday is also a day of supervision—if the state worker gets caught in the town. Rural social workers have worked out their own "harmless artifices" in meeting the numerous types of supervisors, but "they do not approve of stereotyped approaches or responses or slavish adherence to labels of any kind." Yet Miss Strode admits that county workers frequently "take 'em for a ride in the country," which is a method tinged with hoary tradition.

"Tighten the Corner Where You Are—The Search for Job Security Begins at Home." Rural social workers "mixed relationship therapy with roast beef at Rotary Club luncheons," and did many other things, but they found that their "communities were not impressed." By simple comparison they found in their own county "an outstanding example of a secure community service," furnished by those in the cooperative agricultural extension service. The social worker "appreciates the integrity of their spirit of service, and their competence in their work." After studying the extension service, the social workers concluded, "We reasoned that their effectiveness was due not only to federal-state-county backing, but also to the fact that their techniques were the fruit of education in the realities of known conditions and of true understanding of community attitudes and aspirations." [3]

In *Rural Routes to Community Understanding of Public Welfare Programs,* Betty Barton and Florence Black have compared experiences through exchanges of letters. They have set down various

guides to rural social work practice. For example, when you introduce a new worker to the county, it is best to say briefly that "Miss Katherine Gibson of Goodwater, Iowa, has been selected to be the child welfare worker in the demonstration unit," because "too much publicity about her would tend to make the folks think that she was a bit superior." Other professional people who work effectively in rural communities "have come into the community quietly and taken their places inconspicuously. It would be better if social workers followed this pattern."

When you do publicity, these authors go on, it is well to note that "Gulliver County likes work projects, but worries about spoiling people with too much relief." There are frequently "disastrous results of a simple lack of courtesy." The rural newspaper is a rural institution that is fearfully and wonderfully made, and woe unto you if you do not know its ways. When you are working with farmers, they say, there is no substitute for knowing what it takes to be a farmer. Once a farmer told a social worker after a bad storm that "except where the crops were hit by hail not much harm had been done." But he said, almost as an afterthought, "I lost ninety head of cattle, though." The social worker could not find words to express her sympathy in his loss. "He fingered his hat for a moment. 'Well, I'll try again next year,' and he walked out of the office." [4]

Gertrude Springer sums up, in her foreword to *Rural Routes*, "After observing a good deal of social work interpretation, conscious and unconscious, and savoring some of its fruits, both sweet and sour, I have come around to the conclusion, satisfactory to me if to no one else, that effective interpretation is less an activity than a relationship; more an emanation than a process. Note that I am speaking of interpretation, not of publicity. To my mind, they are horses of quite different colors, though excellent team-mates. Publicity, as I see it, is a conscious effort, employing definite methods, directed toward a definite purpose; interpretation is something that goes on all the time whether the interpreter knows it or not. And the interpreter is not some one in particular, but is everyone of high estate or low, connected in any way with any social agency. Awareness that this interpretation is constant and that everyone is doing it, is, I submit, a factor in its effectiveness. We can't all be sure we're

good because we are unconscious." This was written after Mrs. Springer recalled that she had observed a rural social worker who was highly respected and had asked her what the program of community interpretation was. "The poor woman almost collapsed. . . . 'I haven't any.' " But Mrs. Springer wished "that a lot of people who knew more about it could show as good results." [5]

CONFERENCE AND COOPERATION

When a group of agencies in Georgia launched their citizens' Fact-Finding Movement, involving cooperation among officers of many agencies, they soon discovered their first fact: "It was the exception when the head of one of our organizations knew personally the head of another." In Massachusetts, too, state organizations are sponsoring a systematic "get-acquainted effort" among the officers of many agencies. At the county seats, where most rural social welfare work is administered, there are usually opportunities for the persons responsible for an agency to come to know those identified with others. Yet contacts are frequently haphazard. Rural social workers generally feel that the device of the council of social agencies, so frequently used in cities, is not adaptable to rural counties. For one thing, in most counties there are relatively few agencies engaged in rural social welfare, strictly defined. Where agencies are few in number, resources limited, and work programs heavy, it is always a question as to who should lead the way in conference and cooperation, how systematic relationships should be maintained, whether one agency should carry a continuing responsibility of bringing people from other agencies together, and so on. Yet it is certain in rural as in urban areas that relationships among agencies are always important, even if they are always difficult.

There are reports that World War II stimulated the coming together of agencies engaged in agricultural war programs, on the initiative of the United States Department of Agriculture. Frequently a clergyman, a superintendent of schools, and representatives of civic agencies sat on these boards. In certain counties, the Department has encouraged intensive efforts toward a "unified program." Arlien Johnson told the National Conference of Social Work in 1940, "The coordinating council and the community coun-

cil have met an enthusiastic reception in small towns during the last few years, because they have been primarily citizens' councils whose interests were in problems more than in agencies." [6] There is much testimony, however, to the effect that the smaller the town, the more difficult the task of organizing a community council of citizens and keeping it functioning on tasks that the participants regard as significant. Many community councils in the smaller places become gatherings where agreements are made with respect to the community calendar of events. In other instances, a central place is provided—for example, any community agency may post the announcement of a scheduled event on the post-office wall, and others may then plan their own affairs so as not to be in competition.

There is a marked tendency for each agency to set up its own advisory group or committee, made up of lay persons who become an informed group. They then become mediators of programs under way to the people and organizations of the town or county. Martha C. Wood summed up a discussion of such citizens' committees at the 1941 National Conference of Social Work by saying that they help to "interpret programs, determine needs and develop resources to meet those needs." In many places, these citizens' advisory groups already have served an important function. The relation between the professional worker and these committees thus becomes crucial in determining whether a program is "like a fungus on a tree or something which is a part of the permanent life of the community." [7]

A high degree of integration of services has taken place under the Monmouth County Organization for Social Services, Inc., in New Jersey. It receives both public and private funds. It administers 21 services, including mental hygiene clinics and public health nursing. There are no less than 31 public health nurses on the M.C.O.S.S. staff, and also 29 on the staffs of cooperating organizations. In 1945, the total budget was $123,990, of which various government agencies contributed more than $50,000. There is a wide dental-care program in operation. A mobile tuberculosis clinic has served as many as 3,000 migrant farm workers. It is one of the broadest county programs under one administration in the United States.[8]

Marjorie J. Smith, writing on rural community organization, states:

Probably one of the best devices for advancing cooperation among agencies is the case committee or a discussion group of workers from various agencies who are interested in the same family or individual. Nothing works better to clarify the position and function of each agency in such a situation. This is probably most effective in children's cases, although there is no reason why it should not work with any case. . . .

Councils can be organized only as a real need is demonstrated by the community or a desire for such participation is voiced by various community groups and individuals. For what does the community feel a need? The lay group is not interested in forming a council for general welfare problems. The purpose must be specific and the organization will grow as it awakens to greater needs.[9]

Except for their contributions to state war funds, rural communities generally have not participated in cooperative fund raising, as in cities. District developments are becoming more extensive, as cities are able to cooperate with rural communities, and as the latter realize that they are receiving direct services from urban agencies in return for the contributions of rural citizens. After World War II, it was hoped that the smaller communities would join with one another in workable districts and thus finance their own voluntary social welfare services by means of the community chest technique. It was hoped to set up a central office which could serve a number of smaller communities in the area. Latest reports indicate that such plans have not materialized. Another approach is to broaden functions so that there would be, in the smaller cities and larger towns, a community council which would perform in one agency the functions that the chamber of commerce, the community chest, the council of social agencies, and the city planning commission carry on in the larger centers.

A rural teacher, Julia Weber, recounts her experiences in a book entitled *My Country School Diary*.[10] A social worker, on reading it, observed that Miss Weber was doing informal social work "half the time at least." This will illustrate the interdependence of the social welfare enterprise with the other educational, economic, and religious resources of the rural areas. Josephine Strode, as noted above, learned significantly from the agricultural extension service, which has worked with farm people in informal groups in practically all counties on all manner of projects relating to agriculture and home-

making. The Grange, the Farm Bureau, the Farmers Union, and the cooperatives for buying and selling are prominent among the rural resources. About half of the rural people are reported to be church members. The county supervisor of rural schools, "the helping teacher," is frequently working on tasks of social adjustment, as well as at problems of education in the classroom. Social workers frequently have advocated rural public libraries, or traveling library services, which are, like welfare services, not available to most rural communities. Where organized welfare work is new and financial capacities are limited, the proper use and development of all community resources assumes the greater significance. A useful guide for the rural worker on this entire subject has been written by Gertrude V. Withers, *Effective Rural Social Work through Community Organization.*[11]

Wayne McMillen thinks it "not unlikely" that the public county welfare office will eventually become the main agency for furthering cooperation among rural social welfare agencies. He believes that comparatively few urban public welfare offices have assumed responsibilities for community organization activities, but that the rural public welfare agencies "have demonstrated under . . . widely varying conditions considerable capacity in community organization." There is need for leadership, and even "though the demand may not be definitely articulated, it is clear that many of the rural communities expect the public agency to rise to the situation." A major service is that of guiding and advising inexperienced people who manifest concern. "A men's service club wants to do something for underprivileged children. Since it does not know who these children are or what they need, it turns to the county welfare bureau as the logical place to seek advice. A church society makes quilts to give to needy families. The county welfare director is consulted, for he knows all the needy families in all parts of the county. An importunate cripple approaches a kindhearted clergyman again and again for aid. At length, in desperation, the clergyman asks the county welfare bureau what he should do." Thus the rural people are looking upon the county welfare office as a "permanent resource." [12]

As Professor McMillen also has summarized, "There is considerable variation in the structure and in the duties of county public wel-

fare agencies. Some of them operate under elected county officials. . . . Others are directed by unpaid boards of lay citizens. Still others are controlled by the state department of welfare and have very tenuous roots in the local community. Some have one or more advisory committees. . . . The service programs of these county agencies also differ considerably from state to state. Some may handle only one type of relief, while others may be responsible for three or four types of public assistance, for child welfare services, for almshouse admissions, and similar services."

THE SEARCH FOR UNITS OF LOCAL ADMINISTRATION

The county is the prevailing local unit of organization. The conspicuous exception has been the New England towns, and there inter-town cooperation is being practiced to a limited degree. But in the past few years there has been in process a wide search for a local unit of administration even larger than that of the county. In many instances local public health facilities are now administered in units whereby two or more counties, or a city and a county, share facilities and cooperatively administer the local services. Also, in a good many cases, rural public health facilities are administered directly by states through district units. Rural child welfare services are frequently organized in units of more than one county. Among voluntary agencies, for example, the Boy Scouts of America and the Young Women's Christian Associations have generally disregarded county lines. The Young Men's Christian Associations have sometimes organized rural work by cooperation between a city and its surrounding rural communities.

Cooperation among counties in providing social welfare facilities is now widely permitted by state laws. At least twelve states permit some kind of joint maintenance of county almshouses or workhouses. Notable changes have been made in Virginia, which in 1918 had about a hundred almshouses and by 1934 only thirty-two. But Virginia is not typical—elsewhere inter-county cooperation has proceeded more slowly.

Inter-county cooperation is one of the means widely recommended to deal with a difficult situation that has developed in the administration of local welfare services. The simple fact is that the traditional

machinery of county government was established in a day when the needs and concepts of rural public welfare were far different from our own day. Indeed, Lane W. Lancaster, an authority on rural government, states that in the relation of the county to the emerging public welfare needs there are "perhaps more rigidities" than in the performance of other governmental functions. The county administration of the relatively newer forms of social welfare services has been largely on state and federal initiative. As for the older functions of local government: "Neither outdoor nor indoor relief has been well-managed; nor has the system made any contribution at all toward the economic rehabilitation of its beneficiaries." [13] Yet the needy persons have reached their state as a result of many factors which are not at all influenced by the mere extension of unsystematic material relief, frequently in the form of grocery orders. Professor Lancaster believes that rural opinion is gradually coming to favor the method whereby social services are so organized that a small committee of lay people may function in an advisory capacity, and that administration will be carried by professional persons.

Another approach has been to encourage more efficient and responsible local government by means of generating a real cooperation among its divisions and a high degree of citizen interest. "Is democracy at the grass-roots capable of taking a more responsible role in our highly complex system of government?" This was one of the questions faced by those who participated in the Blue Earth County Council on Intergovernmental Relations, in Minnesota. Many citizens of Blue Earth County have attempted to return a positive answer and have labored toward re-establishing local self-government. This county has been one of the local areas cooperating with the Council on Intergovernmental Relations, a body which had administered an experimental program financed by the Spelman Fund of New York.

The proposal for the experiment was submitted to the Fund by the late Harold D. Smith, when he was director of the federal Bureau of the Budget. The Blue Earth County Council on Intergovernmental Relations is "promoting collaboration among the city, town, school and county governments in their common purpose, acting as a clearing house for proposals relating to municipal, county, or

school legislation; promoting public interest in intergovernmental relations; collaborating with each of the local governing bodies in setting up budgets, making recommendations for new services or for discontinuing existing services; and serving in any additional capacity for the good of the community" to which it may be assigned by joint action of the government units concerned.[14]

When the Council was organized, the next task was to implement the general authority, in other words, to select a project or activity—"something to do." This was not easy. The Council turned to the budgetary process for the answer. A "community budgeting" process is being worked out. The purpose is not to control or supervise the units of government but "to assist them by providing a complete and usable report on all governmental activities being carried on within the community," and to help in various other ways throughout the budgeting process. Other experiments have been carried on in Colquitt County, Georgia; Santa Clara County, California; Skagit County, Washington; and Henry County, Indiana. A few counties and towns in the United States have endeavored to coordinate county government functions through the employment of full-time managers.

For administration of local rural welfare programs there is a definite national trend toward larger units of local administration. This has proceeded so far as to call for inter-county units and also for streamlining of the local government machinery.

THE "RURAL PLUS" IN TRAINING

The various phases of social welfare work have their "rural aspects," and the matter of training is no exception. The basic subject matter of education for rural social work may be no different from that for other work, but rural social workers frequently express themselves with respect to both the overtones and the undertones of education and training which they deem necessary to prepare a person for the rural job. Obviously we can deal here not with training in general, but solely with the "rural plus" in training.

Mattie C. Maxted of the University of Arkansas, in "Don't Forget Your Country Cousin," an article published in the *Survey Mid-*

monthly, states that under the merit system in that state a stenographer in a county welfare office may be paid from $110 to $130 a month, whereas a visitor (social worker) may be paid only $100 to $120 a month, but the formal educational qualifications for visitors are much higher than for stenographers. The visitor must have a high school education and two years of college, or two years of experience instead of college. Miss Maxted believes that in the rural states *undergraduate* courses for social workers "can help break the vicious cycle of poor work and meager funds" by a leavening process. She writes that one-third of the county visitors in one state have a high school education or less, and that only a small proportion are college graduates. The undergraduate courses will make it possible for these workers to improve their skills and services. Graduate schools are now "remote" from great numbers of rural social workers.[15]

A paper on "Training for Rural Social Work" was read by Hazel A. Hendricks of the United States Children's Bureau before the 1939 National Conference of Social Work. Generally, she says, educators recommend the acquisition of professional knowledge and the development of working skills. "But just exactly what working skills does the rural worker need and how can schools of social work define and impart them?" Miss Hendricks considers the question from the point of view of one interested in training for *rural* child welfare work. Urban field work by students does not prepare adequately "for the exigencies of rural work as it exists today and for the personal adjustments that it demands. Undergraduate courses in economics, political science, sociology, and psychology are important and necessary, as well as the basic graduate social work courses, including family case work, child welfare problems, medical and psychiatric information, public welfare administration, community organization, research and statistics."

The well-prepared rural worker, Miss Hendricks continues, will also need instruction in social insurance, legislation, and public assistance, community organization, group work, and local government. The rural worker will need to be prepared for "criticism from laymen, particularly from those unaware of the complexity and subtlety of work with human beings." Some practical field experience

in handling rural situations will be of especial value. The idea of the internship would be good for rural child welfare workers—their job is so difficult that they should have "a period of protracted but real experience . . . between school-of-social-work education and full responsibility for a job." [16]

Grace Browning, author of the comprehensive volume *Rural Public Welfare*, considered certain aspects of the matter in a paper entitled "Training for Public Welfare Services," which she read before the National Conference of Social Work in 1944. She reported that the land grant (agricultural) colleges of the South and West had formed an "association for the purpose of accrediting schools that are preparing social workers on an undergraduate basis." Faculties of graduate schools of social work and those of liberal arts colleges have met during recent years in "area conferences" for discussion of "common interest in recruitment and professional education." It is hoped that there may be a "better vocational guidance of students with an interest in social work," stronger undergraduate courses in the social sciences, and a closer cooperation between liberal arts colleges and graduate social work schools in the development of curriculum. Some colleges are offering "pre-social-work majors, recommending to the student instruction that includes political science, economics, psychology, sociology and cultural anthropology."

Miss Browning notes that "courses closely related to social work that are being taught successfully to undergraduates include the history of social welfare," labor, public health, social surveys, statistics, government in relation to social welfare. "There is need of further experimentation and study in this area." Miss Browning sees as another possibility the "freer exchange of personnel between the operating agencies and the schools." She makes this reference to the graduate schools: "Perhaps the graduate schools should face the possibility that their greatest contribution to the public welfare services lies in the preparation of administrators, supervisors, field representatives, child welfare workers, and specialized and general case consultants who can aid in the development of untrained and partially trained staff members." [17]

From the foregoing, and from conversations with rural social

workers, the following factors stand out: the dependence, for some time to come, on undergraduate training; the need for supervised rural field work in training; the desirability of acquiring knowledge of rural attitudes and rural social control; the necessity of learning a rural brand of public relations and community organization.

IMPROVEMENT OF RURAL SOCIAL WELFARE SERVICES

From among many recommendations from varied sources, the following proposals are set down. They are given as a brief listing, rather than in the form of documentation with data. In each case, what has gone before in this book is related to what follows. In other words, the case for what follows has been made throughout the previous presentations.

1. Federal grants to the states for social services should be made on a variable basis, the states with the lowest per capita income and other economic resources receiving relatively the largest aid.

2. There should be federal participation in "general assistance" or general relief, because this is the only type of assistance or relief available in the states to incapacitated adults other than the aged and blind, to unemployable and underemployed persons, and to children who have come to need for reasons other than death, absence, or incapacity of the parent.

3. The coverage of old-age and survivors' insurance should be extended to the rural population, including farm and village people and professional persons working for nonprofit, voluntary organizations.

4. The construction of a complete system of general hospitals and rural health centers should become a national responsibility, because the creation of hospital facilities is one means of eventually attaining good medical care for the rural community.

5. The creation of local units of social welfare administration larger than the county should be generally encouraged for both governmental and voluntary agencies, but especially for the latter.

6. Public health facilities in accordance with some minimum standards should be made available to the entire rural population, preferably through county-city units.

7. The availability of public health nursing should be recognized

as a basic right of all the rural people of the nation, and public resources should be forthcoming for this purpose.

8. Steps should be taken to evolve a long-time federal policy of public grants-in-aid for rural social services, rather than categorical grants, and the needs of minority groups in the rural population should have special recognition.

9. The work of voluntary agencies serving youth should be both expanded and intensified; it is especially desirable that free and varied activities, with no governmental direction, be available to rural young people.

10. There should be national resources available for equalization of school opportunities for rural boys and girls, as compared with those of urban communities.

11. The religious bodies of the nation should give special consideration to appropriate ways whereby they could encourage the development of rural health and welfare facilities and services.

12. The social needs of migrant laborers should be met by a long-time, federal-state program, which would assure them, first, of a national employment service and, secondly, of access to the basic social welfare and educational services expected in the normal American community.

13. All the rural leaders of the nation should consider anew the rural social welfare situation and the ways and means of meeting it, especially the increasing responsibilities for welfare work with children; the improvement of medical care, including provision for the chronically ill; and the redirection of many programs for the large numbers of older persons in the community.

14. All rural agencies should take responsibility for assisting in the pooling of resources for the development of noncommercial recreation centers in rural communities.

15. Citizens' committees consisting of representative city people and farm people should be formed to work toward national standards of social legislation for urban and rural people, including control of rural child labor. The rural people should not continue to be largely excluded from social legislation.

16. Rural social welfare services should be improved and extended by the generous cooperation of social welfare workers with

those of the other rural agencies and institutions. The clergyman, the educator, the officer of the general farm organization and of the cooperative all have appropriate and indispensable functions in the development and maintenance of rural welfare services. Practical methods of cooperation should be devised in counties, districts, and states and among representatives of national agencies.

Cooperative Health Federation, 343 S. Dearborn St., Chicago 4, Ill.
Cooperative League of the U.S.A., 343 S. Dearborn St., Chicago 4, Ill.
Cooperative Recreation Service, Delaware, Ohio
Council of Southern Mountain Workers, Berea, Ky.
Credit Union National Association, Madison 1, Wis.
Family Welfare Association of America, 122 E. 22d St., New York 10, N.Y.
Farm Foundation, 600 S. Michigan Ave., Chicago 5, Ill.
Federal Council of the Churches of Christ in America, 297 Fourth Ave., New York 10, N.Y.
Girl Scouts, 155 E. 44th St., New York 17, N.Y.
Group Health Federation of America, 200 Main St., Little Rock, Ark.
Home Missions Council of N.A., 297 Fourth Ave., New York 10, N.Y.
Jewish Agricultural Society, 386 Fourth Ave., New York 16, N.Y.
W. K. Kellogg Foundation, Battle Creek, Mich.
Life Insurance Adjustment Bureau, 450 Seventh Ave., New York 1, N.Y.
Elizabeth McCormick Memorial Fund, 848 N. Dearborn St., Chicago 10, Ill.
National Catholic Rural Life Conference, 3801 Grand Ave., Des Moines 12, Iowa
National Child Labor Committee, 419 Fourth Ave., New York 16, N.Y.
National Committee for Mental Hygiene, 1790 Broadway, New York 19, N.Y.
National Conference of Social Work, 82 N. High St., Columbus 15, Ohio
National Congress of Parents and Teachers, 600 S. Michigan Blvd., Chicago 5, Ill.
National Council of Farmer Cooperatives, 744 Jackson Place, Washington 6, D.C.
National Education Association of the U.S., 1201 16th St., N.W., Washington 6, D.C.
National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N.Y.
National Health Council, 1790 Broadway, New York 19, N.Y.
National Lutheran Council, Welfare Division, 231 Madison Ave., New York 16, N.Y.
National Mental Health Foundation, Box 7574, Philadelphia 1, Pa.
National Organization for Public Health Nursing, 1790 Broadway, New York 19, N.Y.
National Probation Association, 1790 Broadway, New York 19, N.Y.

National Recreation Association, 315 Fourth Ave., New York 10, N.Y.
National Social Welfare Assembly, 1790 Broadway, New York 19, N.Y.
National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N.Y.
National Tuberculosis Association, 1790 Broadway, New York 19, N.Y.
Public Administration Service, 1313 E. 60th St., Chicago 37, Ill.
Salvation Army, 120 W. 14th St., New York 11, N.Y.
Social Legislation Information Service, 930 F St., N.W., Washington 4, D.C.
Southern Rural Life Council, Nashville, Tenn.
Young Men's Christian Associations of the U.S.A., 347 Madison Ave., New York 17, N.Y.
Young Women's Christian Associations of the U.S.A., 600 Lexington Ave., New York 22, N.Y.

U.S. GOVERNMENT AGENCIES

The following agencies may be addressed at Washington, D.C., except as noted.

Department of Agriculture
- Extension Service
- Farmers Home Administration

Department of the Interior
- National Park Service
- Office of Indian Affairs

Department of Justice
- Board of Parole
- Bureau of Prisons
- Immigration and Naturalization Service

Federal Security Agency
- Office of Education
- Office of Vocational Rehabilitation

Social Security Administration
- Bureau of Employment Security
- Bureau of Old-Age and Survivors Insurance
- Bureau of Public Assistance
- Children's Bureau

Tennessee Valley Authority, Knoxville, Tenn.

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